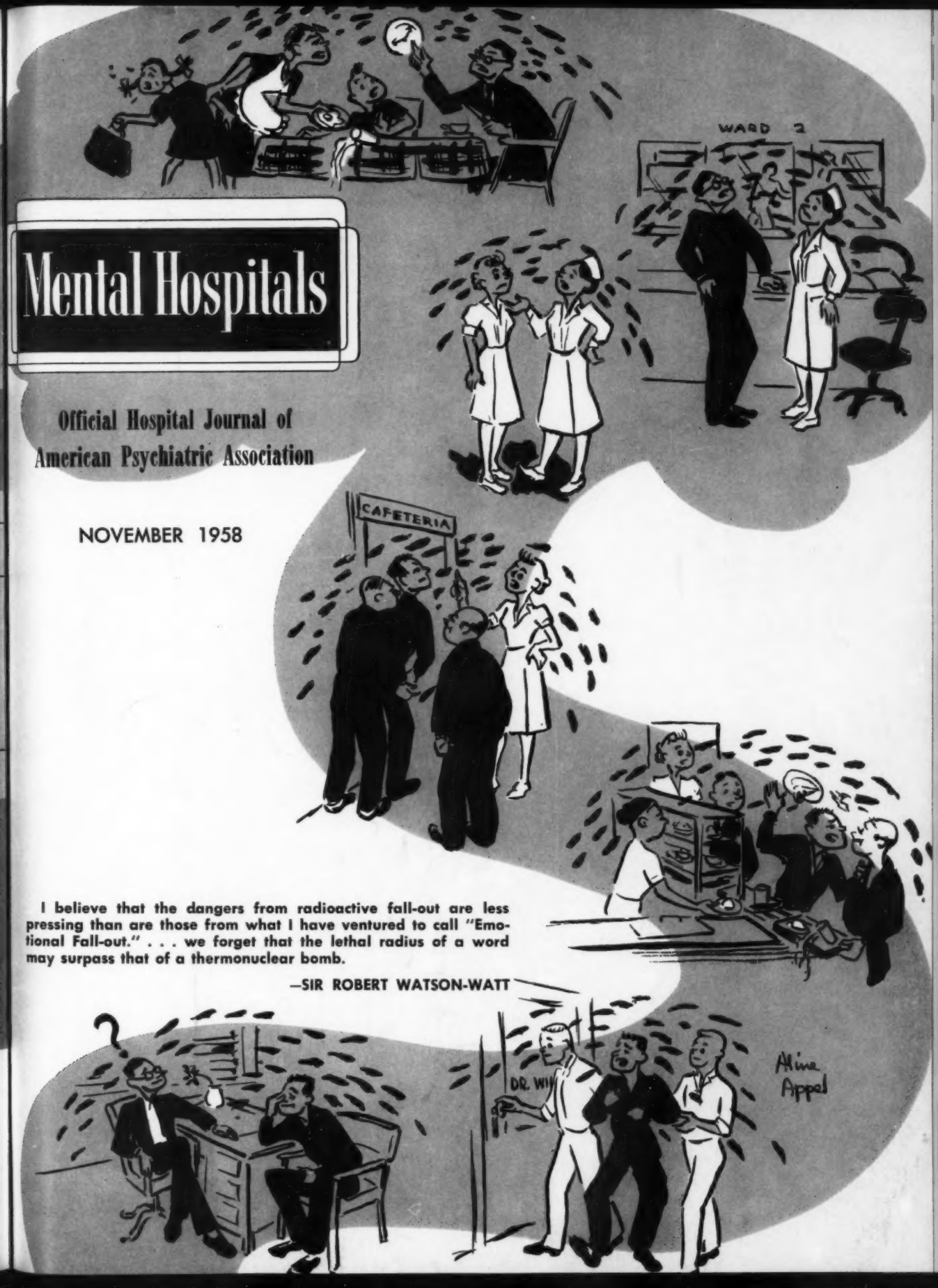


Mental Hospitals

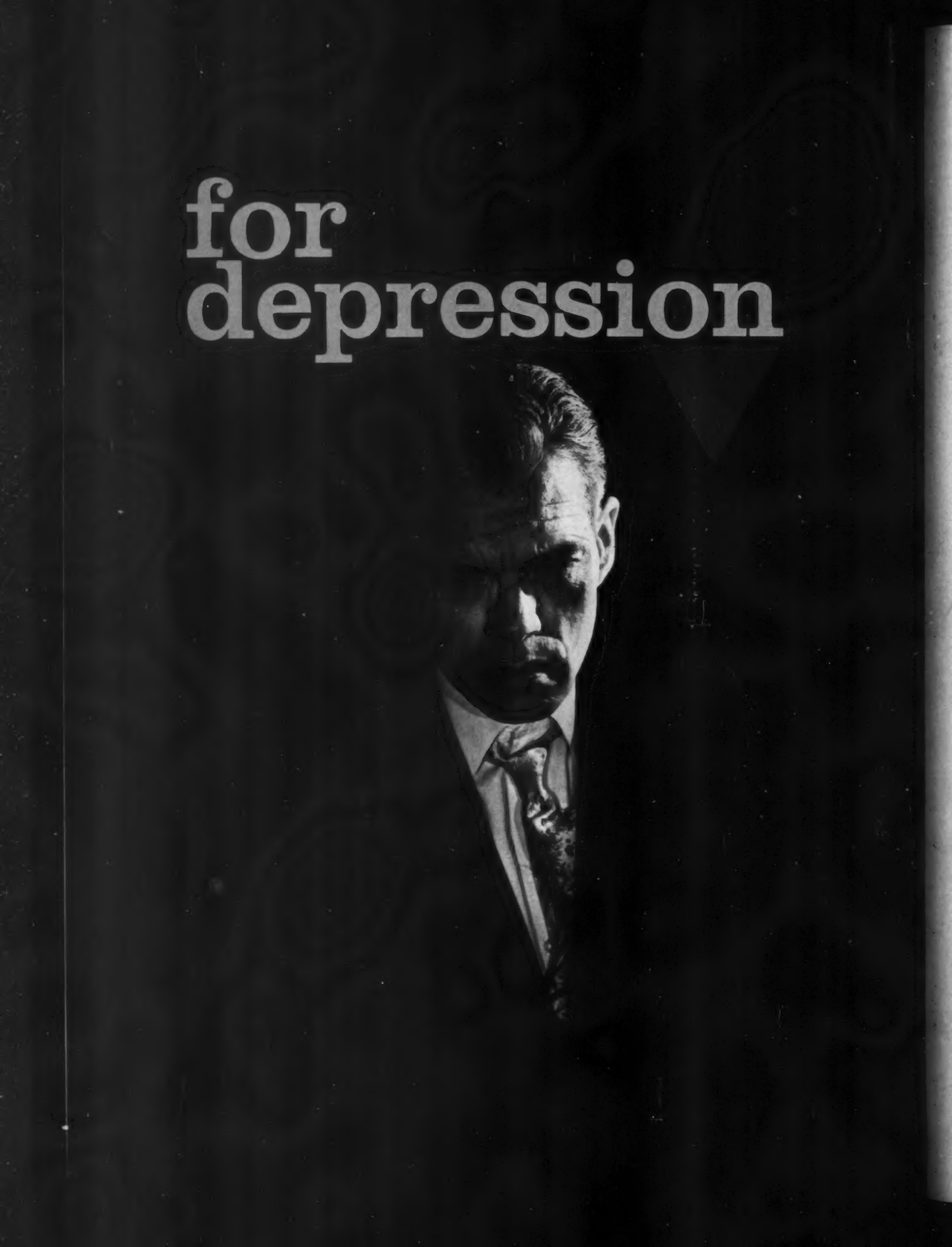
Official Hospital Journal of
American Psychiatric Association

NOVEMBER 1958

I believe that the dangers from radioactive fall-out are less pressing than are those from what I have ventured to call "Emotional Fall-out." . . . we forget that the lethal radius of a word may surpass that of a thermonuclear bomb.

—SIR ROBERT WATSON-WATT

for depression



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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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Mental Hospitals

VOLUME 9 NUMBER 9

Published monthly, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Subscription price: At the rate of $6.50 a year each, up to 44 copies of each issue are included in the dues, which range from $50 to $350 a year for institutional subscribers, based on the number of beds in an institution. Individual subscription rate (for staff members of subscribing institutions only) $6.50 a year. Limited Service subscriptions of $25 a year for related professional organizations and mental hygiene societies include 5 copies of each issue. Published by the American Psychiatric Association Mental Hospital Service, 1700 18th Street, N.W., Washington, D.C. Entered as Second Class mail matter August 1st, 1952, at the Post Office, Washington, D.C. under act of March 3, 1879.

OFFICIAL HOSPITAL JOURNAL OF
AMERICAN PSYCHIATRIC ASSOCIATION

CONTENTS, NOVEMBER 1958

This Month's Cover

The quotation illustrated on this month's cover was suggested by an item which appeared in THE INDICATOR, Bulletin of the Utah State Hospital.

Sir Robert's paper "Emotional Fall-out", which deals with the human element in the age of automation, and mechanization, was published in BULLETIN OF THE ATOMIC SCIENTISTS, June 1958.

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The Psychiatrist Looks at Administration

By NORMAN C. MACE, M.D., Director of Professional Services
and HUBERT A. CARBONE, M.D., Assistant Director of Professional Services,
Veterans Administration Hospital, Sepulveda, Calif.

THE ADMINISTRATOR of a hospital often assumes, for conscious or unconscious reasons, a role comparable to that of the therapist. In some instances he may be forced into that role, without awareness on his part, by the individuals whom he supervises. In others he may be fully cognizant of the role, and assume it because people in his organization come to him for assistance.

He will discover that he must not allow his own emotions to influence him when dealing with the anxieties of his staff; that he must make decisions which will satisfy one group of employees but are not always to the liking of others; and finally, that he must encourage others to have a better understanding of their problems. He hopes that if employees feel the need for his services in this respect they will come to him.

He will often be aware that some individuals, for unconscious reasons, may use him for their own interests, and can only hope that extensive projection on their part will not be necessary. If he is interested in behavior, he will reflect upon the stress reactions of those with whom he is associated and will try to determine whether their responses are due to situations at home or at work. He may attempt to surmise the etiology of particular responses both by himself and by others.

The psychiatrist-administrator may feel that he sacrifices much in not being able to carry on clinical work with individual patients. But he can secure some satisfaction by reflecting that the basic tenets of psychiatry are workable within an organization of employees as well as with patients. Like the ward therapist, he must recognize his own weaknesses and his reasons for reacting to others as he does. He may find that his reaction to others or to situations follows a repetitive pattern which is based upon his own motives and which causes him to be successful or to fail. Much of the ideation of the administrator, he will find, is left unsaid—and perhaps for the best!

Need for Administrator to Know his Staff

He will discover that he can easily misinterpret the feeling-tone of his personnel for two main reasons. One is his tendency, because of lack of time, to communicate mainly with chiefs of service; he may thus be quite unaware of the attitudes of the many others who are not able to express their ideas to him directly. Secondly, he will communicate often with people who, for reasons which have to do with their own needs, demand his time through attention-getting devices. His attention can be so taken up by these people that he can easily overlook the needs of valuable members of his team who go about their daily work without complaint. The loyal, hard-working individual can feel rejected under such circumstances, but because of his personality, will not voice complaints until a conflictual situation is far advanced.

The psychiatrist-administrator will be aware of the common attitude of people who are supervised—to wit, that he is a powerful figure who does not give them as much attention as he should. They may think of him as authoritarian rather than permissive, critical rather than forgiving and unaware of their needs and problems. Even though his chiefs of service are conscientious and try sincerely to reflect both the personnel's needs and the administrator's policy, this will not be a satisfactory substitute for personal communication between administrator and employees. Many of the attitudes described can be dispelled if employees can get to know the administrator as a human being. A complete solution to this problem can never be reached, but in this hospital a partial solution has been attempted by having groups of employees below the supervisory level meet at intervals with the administrator. One of the administrative problems needing continuing study is the means by which the gap between administrator and employees can be narrowed and still kept within the limited time available in a busy work day.

Development of a New Hospital

The development of the organization in this newly activated hospital has been so interesting from a dynamic viewpoint that the authors, both experienced psychiatrist-administrators, believe that an examination of it may be of some value to others, both in new hospitals and in older institutions where patient treatment and staff management philosophies are changing.

The hospital was activated in April 1955. There are 955 beds of which 665 are for psychiatric patients, 120 for tuberculous psychiatric patients and 170 for non-psychiatric general medical and surgical patients. Thus, as in all hospitals, many professional and sub-profes-

The Editor's Notebook

What do you think about the various points of view advanced by our authors this month? I'd like to have more of our readers "answer back" and will undertake to publish particularly pertinent comments in a "Letters to the Editor" column.

For instance—and I'm referring to THE PSYCHIATRIST LOOKS AT ADMINISTRATION by Drs. Mace and Carbone (Page 5)—is it possible for employees to "know the administrator as a human being"? Doesn't his father-role interfere with such an objective relationship? And how else can a physician deal with the communication problem besides "streamlining regulations"?

Turning for a moment to Dr. Kimmich's paper, THE YOUNG PSYCHIATRIST IN THE MENTAL HOSPITAL (Page 9), I'd especially like to have some comment from younger physicians. What should be the ward psychiatrist's role in relation to the other professional workers in the hospital? And does the hospital framework perhaps lead to over-dependency on the part of the resident?

These are only a few questions which occur to me—you'll have many more, I'm sure, both on these two papers and on other articles in this issue. Please keep your communication short—not more than one page, unless you feel you have enough opinions to make a full-length article. (We've had an interesting reply from Drs. Osmond and Clancey of Saskatchewan, for publication next month, to COMMUNICATION—THE PULSE OF THE MENTAL HOSPITAL, by Messrs. Dolgoff and Sheffel, which we published in the September issue.)

Let's hear from you!

MATHEW ROSS, M.D., Editor.

sional individuals have had to be welded together for a common purpose.

Because the psychiatric service is our largest one, the early activation of the hospital and most of the observations in this paper concern the administrative problems of that service.

Type of Structure Designed

The organization and growth of the hospital reflected the new philosophy of administration found in psychiatric hospitals as well as in industry, and resulting from an attempt to substitute a democratic structure for the old-style authoritarianism. Today's administrators, whether psychiatrists or industrialists, are conscious of the need to make their organizations attractive places in which to work. The hospital administrator realizes that his personnel must be able to derive satisfaction beyond high salaries and fringe benefits and feels fortunate if he can provide the professional incentive of a good therapeutic milieu where research and teaching are encouraged. He knows, too, that to keep well-qualified personnel, it is necessary to give them a voice in management.

These considerations make for slower development in new organizations as well as tension in old hospitals where the philosophy is changing. The final program, however, is probably better than if the administrator makes sudden changes or dictates rules without consulting the employees or the patients affected. Programs such as the open door policy and the therapeutic community, which involve everybody in therapy problems, are additional reasons for the changes that are taking place today in the management of psychiatric hospitals.

Early Practical Problems

Our professional and sub-professional personnel had been carefully selected, and were perhaps an unusual group because of their combined and various experiences. Each individual faced the problem of identifying with a new group of workers, attempting to bring into the new setting some of the ideas which had seemed right in his previous place of employment, and to contribute to the needs of the new one. In addition to the normal anxiety of such a wholesale adjustment, each person faced the reality of housing problems in a new high-cost area, and this factor served to throw the anxiety symptoms into bolder relief. Another minor but recurring problem in opening this large new hospital was the many requests for supplies and equipment. These requests undoubtedly absorbed too much time and attention from the medical team, which might better have been employed in program planning.

Absence of Chiefs of Service

Unfortunately, the activation of the hospital was so rapid that a number of chiefs of service were not present to take part in the over-all planning until shortly before their respective services opened. Good planning presupposes that all these chiefs are on the job early and that they can, by joint communication, set policy for medical programs within the hospital. This would have made the program proceed more smoothly and might have eliminated many of our early difficulties.

Their absence, however, threw into strong relief the dependency of members of groups upon their leaders. It was impressive how organization became stronger when adequate leaders in each department adopted their roles.

Substitute leaders were not good enough. Even in departments where the permanent leaders arrived early, they could not spend as much time with individuals as they could in older institutions. As a result some individuals felt rejected, and reacted by demonstrating great anxiety and sometimes aggressiveness.

The greatest anxiety arose when roles were uncertain, especially when the planning of a program was slow, either because of lack of staff in the early days, or because the physicians took time to develop the best possible program. Until individuals were told in very definite terms just what their roles were to be, there was a tendency on the part of some to enlarge the scope of their activities beyond what it had been in other institutions, to the partial exclusion of other members of the treatment team.

As increasing numbers of patients and personnel ar-

rived, groups had a tendency to form teams to a greater degree than either of the authors had previously experienced. Sometimes members of a team became so closely identified with the leader that, despite the obvious value of such co-operation, this was undesirable. If the leader was lost or disappointments occurred, the group feeling of anxiety increased the unhappiness of individual members. Too powerful a leader is a similar danger. He can so stimulate his group that they will accept his philosophy unquestioningly. This is not for the welfare of individual group members.

Employees Need Voice in Decisions

It is important to find ways to increase the self-sufficiency of each member of the team to guard against anxiety should the leader be lost, and to prevent individuals who are not leaders from struggling with feelings of over-dependency. Recognition of an employee, kindness and consideration and knowing him as a person are not enough. His primary need is not status, but rather a sense of individual accomplishment. His ego-strength depends upon this feeling. Recently we had complaints that morale in a certain department was not good. It was found that the cause of dissatisfaction was that skilled medical rehabilitation personnel were not able to talk with the physicians and receive advice about their patients. Because of this the rehabilitation people felt that their contribution was not being taken seriously, and that they were being regarded merely as "baby sitters."

Iowa Students Visit Disneyland

Twelve girls and twelve boys from the Glenwood (Iowa) State School visited California in May on a week's trip made possible by the Iowa Junior Chamber of Commerce. Six counselors accompanied the children, who were all between the ages of 11 and 20 and residents of the school for at least two years. The group was entertained by Jaycees at Salt Lake City and Anaheim. The children are shown above entering Walt Disney's Adventureland. Other points of interest were the Mormon Temple grounds at Salt Lake, Grauman's Chinese Theater, movie sets and TV studios in Hollywood, Knotts Berry Farm, and the Little Chapel by the Lake.

Employees need to asume mature roles, and irritations will arise where they feel they are not permitted to do so. Some of our employees were recently given the authority and responsibility of establishing time schedules for others in their departments. Suddenly they found their own schedules had been changed by their chiefs without consultation. The employees affected complained that under such conditions they could not maintain the morale of the others whom they were supposed to be supervising; but who now questioned their authority and consequently lost respect for them.

The physician, as leader of his team, should consult with other members regarding therapy procedures and administrative decisions, such as discharges, which affect the patients. Communication here is very important; without it, tension will arise because mature employees feel that they should have some voice in such matters. Here, however, the physician may find himself in a conflictory situation, because time spent with staff members has to be taken from the time he spends in therapy with his patients. Shortage of staff aggravates the problem. The unhappiness of the physician may be reflected by his demand for more streamlining of regulations, which will not, however, substitute for personal communication.

Whether the hospital is large or small, the administrator will realize that policy is an integral part of planning. Prior to the development of our residency program, some time after the activation of the rest of the hospital, a considerable number of planning meetings were held. All concerned exchanged views, until a final draft of the program was made for permanent structure. This can only result from communication between leaders.

A leader, however brilliant, who cannot communicate properly, is a disrupting influence and can demoralize a staff because of his inability to share planning for over-all policy.

All Personnel are Administrators

The concept of the therapeutic community in pyschiatric hospitals, where patients are encouraged to take an active part in ward administration to increase their feelings of responsibility, has brought all personnel into the role of administrators. They are subject to many of the same pressures as the top administrator himself. They must consider requests from patient groups, and sometimes refuse them for the welfare of the whole organization. They are tested by the patients; they must deal with the anxious, aggressive ones, and those who feel they are rejected. They have to evaluate requests in the light of the reaction of the group. Unless they are able to adopt a mature role, tension will develop in the patient group just as it does among personnel when the top administrator is unable to assume his proper role.

In summary, therefore, one might say that the pyschiatrist-administrator of a mental hospital must have a thorough knowledge of the dynamics of human behavior and motivation if he is to enable his staff to become mature and self-sufficient. This is even more essential if he is to build a democratic rather than an authoritarian structure.

The Young Psychiatrist In The Mental Hospital

By ROBERT A. KIMMICH, M. D., Director of Clinical Services
Illinois State Psychiatric Institute, Chicago.

IN THE MODERN PSYCHIATRIC HOSPITAL, the psychiatrist has the chance to begin the development of his potential with guidance and within the framework of an administrative structure which requires and promotes his maturing as a leader and as a physician. No other field of medicine demands so much of a man as psychiatry. The physician entering into it must be prepared to concern himself with the entire gamut of the patient's existence. The mind, the body, the soul, relatives and friends, the patient's past, present and future—all have importance in the symptom picture, its cause and its cure. At the same time, the psychiatrist must be able to assimilate and appropriately handle this mass of varied data without over-involvement of his own personal needs and weaknesses.

Such responsibility is obviously impossible for any man to accept with completeness and absolute competence. The best he can do, therefore, is seek to approximate this level of understanding and maturity to the best of his ability.

The young psychiatrist attempting to build broad comprehension and sound emotional maturity in this relatively abstract field needs a definite frame of reference. This is usually supplied by his hospital or clinic organization, his supervisors, his clinical and didactic training experiences, and his reading. Without this framework the resident must cling to his own attitudes and defenses, and may be unable to give them up, thus holding on to a rigid, narrow view frequently incompatible with good judgment and assimilation of available data.

Effective Therapy Requires Skill in Leadership

On the other hand, an overly narrow training approach or too prolonged dependency on supervision may result in insecurity at the end of the residency training years. For this reason G.A.P. recommends gradually increasing responsibility in ward administration and teaching. In addition to the guidance supplied by training experiences, the psychiatrist in the hospital is saved from a hopelessly colossal task by having a variety of trained workers available to help handle various aspects of the problem. The psychiatric nurse, the social worker, the occupational therapist and others are all members of the psychiatric team and can supply information and carry out techniques which the psychiatrist alone could never hope to attempt. For most effective therapy then, the psychiatrist needs to be skilled in leadership so that he may coordinate and utilize the assistance which is available to him. This in turn creates new adaptive needs for learning to deal with colleagues, supervisors and ancillary personnel.

In relation to the patient, the psychiatrist must play two major roles simultaneously. First, he must be a *participant* in the interpersonal relationship and second, he must be an impartial *observer* of the patient and of the relationship. This double role is obviously difficult.

In addition, he must be able to accept supervision in a useful way and must have the personal strength to adhere to a treatment program which will be best for the patient. He must apply his judgment and act on it. If he is not sure enough of his own judgment, he must be willing and able to get help and consultation from appropriate sources. In the long run, the psychiatrist faces the necessity of making decisions and actions based solely on judgment and opinion. This emphasizes the importance of training and development of the ability to form a sound judgment either with or without the help of others.

Psychiatrists Need Flexible Talents

Generally, a psychiatrist needs the capacity to: (1) be flexible and grow emotionally and intellectually, (2) respond to other persons with interest and respect and to communicate well with them, (3) deal with intellectual abstractions, (4) seek and utilize professional training, (5) develop enough understanding and control of his own emotional problems and attitudes so that he can work to minimize their negative effect on his work, (6) assume fully the responsibilities of his role and position (this applies to his relationship with patients, families, friends and the community, as well as his social group, his hospital or clinic, and colleagues), (7) avoid over or under-evaluation of his skills, (8) be an accurate observer, (9) maintain mature and effective relations with his co-workers, (10) understand the structure, meaning, advantages and disadvantages of authority relationships. (This bears directly on some of the problems involved in the patient-doctor relationship. It also touches the doctor's personal ways of dealing with conflicts over dependency versus independence, hostility versus masochism, aggressiveness versus passivity, and affects his attitudes toward his part and the part of others in administrative action, and in the training situation.)

Because of the multiplicity of professional disciplines which come together in the hospital, it is the best setting for the new psychiatrist to study a wide variety of patients and different psychiatric techniques. It provides him the best opportunity to bring therapeutic resources to bear on the patient and the family, and supplies him with a supportive framework while at the same time enabling him to gain broad insight into his chosen profession.

EXPANDING HOSPITAL SERVICES WITH THE AID OF COMMUNITY PHYSICIANS

By CHARLES E. GOSHEN, M.D.

Project Director, A.P.A. General Practitioner Education Project,
Washington, D. C.

APART FROM THE ever-present problem of money, the most serious handicap to supplying our mental hospital patients with the quality and quantity of service they need and deserve is the shortage of trained personnel, especially of psychiatrists. Although the number of young men entering psychiatry is increasing at an encouraging rate, the state and federal hospitals are not benefiting very much from this increase, since private practice and other fields seem to offer greener pastures to these new psychiatrists. Thus, unless something happens to reverse this trend, mental hospitals will need to exploit other sources to meet their need for medical personnel.

To name only a few of the obvious sources of additional help, the mental hospitals can attempt to attract more foreign physicians; this plan is much in evidence but has the distinct disadvantage of introducing a language problem which is a serious handicap in our specialty. The hospitals can establish more extensive training programs, preferably in conjunction with medical schools; this type of program offers important professional incentives to attract and hold qualified men, and also offers the possibility of utilizing the service of the trainees. And finally, they can develop a program of using general practitioners on a full-time, part-time or even a trainee basis. Effective physician recruitment can be developed within the framework of the last two programs.

Congress Appropriates Funds for Training G.P.'s

The 85th Congress has appropriated a sum of $1,300,000 for the National Institute of Mental Health to finance the psychiatric training of general practitioners. Mental hospitals and other psychiatric training centers are eligible for grants under this program. In this fiscal year 1959, $800,000 of the total is available to provide stipends for general practitioners who wish to take standard psychiatric residencies, but are financially unable to do so under the existing salary scales. The money for these stipends will be granted to the training center, not to the trainees, and the N.I.M.H. will rely upon the judgment of the training center to determine the qualifications of the trainee and the salary to be paid him. While no criteria have been specified, it is expected that no physician will ordinarily qualify for a stipend under this grant unless he has been legitimately in medical practice for about four years or more, and has family commitments which render the usual resident's salary inadequate. (Without these provisions there would be a serious disruption of the existing practice of training younger residents who have not been in practice.) Besides the actual stipend, other money can be made available to the training center to pay for any additional staff required to conduct the enlarged training program. This program will enable many general practitioners to specialize in psychiatry who would otherwise be unable to afford this training.

The remaining $500,000 of the original Congressional appropriation will be made available as grants to finance post-graduate psychiatric courses for general practitioners (and other non-psychiatric physicians). Any psychiatric training centers, such as medical schools, mental hospitals, or any other facilities which might be developed by the District Branches of A. P. A. in cooperation with other medical societies, are eligible to apply for grants under this program. The General Practitioner Education Project has found widespread interest on the part of general practitioners who wish to take postgraduate training in psychiatry in order to be able to better evaluate and treat the many emotional problems they meet in their everyday practice. Mental hospitals are logical places to develop such training programs, but they are often handicapped by shortage of staff and money. Under these new grants-in-aid, a hospital can set up a program which would employ teachers from more distant places, thus offering a valuable service to the local general practitioners as well as enhancing the training facilities of the hospital. The public relations value of such a program can be considerable. Whereas every state has at least one state hospital, the principal psychiatric training centers are usually in large metropolitan areas. Under this type of training program, however, the state hospitals could supply the clinical facilities and the site for postgraduate courses, and the teachers could be brought in from the outside.

One of the major areas in which the mental hospitals can profit from a closer liaison with local G.P.'s is in the development of follow-up programs for discharged patients, who come again under the care of their family physicians. In order to capitalize on these after-care resources, however, the hospitals must take leadership in offering some guidance and training to these physicians. With the help of some postgraduate courses and access to consultations from the hospitals, a large number of family physicians will become interested in sharing the responsibility for the after-care of these discharged patients. Without such training and assistance, the average general practitioner is understandably reluctant to follow up mental patients. One hospital in Pennsylvania which instituted an active liaison program with local G.P.s' believes that as a result, its re-admission rate has dropped from 35% to 20%. A second way in which mental hospitals might promote assistance from community physicians is by using them as part-time

doctors, undertaking the medical care and routine physical examinations of patients. This is done in some hospitals, but is rarely exploited to its greatest advantage. General practitioners who put in one or two days a week in a mental hospital frequently become interested in taking some psychiatric training, which would in turn benefit the community. It is reasonable to expect that the greater the psychiatric skills of the local physicians, the lower the admission rate to the mental hospital will be, a decided long-term benefit to the hospital. Remote communities which may be served by a state hospital but suffer from a shortage of community physicians might find it helpful in recruiting such physicians if the local state hospital could offer newcomers part-time salaried positions.

In Nebraska, a unique system has been devised for the state's alcoholism program, which might profitably be adapted by state hospitals as a way of developing follow-up programs for their discharged patients. Under this system, local physicians' offices are used as follow-up clinics, which can, therefore, be spread over the state. A supervising psychiatrist and/or social worker travels around and visits these local "clinics" at regular intervals to offer consultation service. The local physician is responsible for the after-care of the patient, but is enabled to undertake this because of the itinerant consultation service. A team of one psychiatrist and one social worker could supervise a "clinic" program of this sort, utilizing the services of about fifteen local physicians, each of whom would be responsible for the after-care of about ten patients at a time or about 25 a year. Thus a fairly high quality of after-care service could be supplied for three to four hundred patients a year, with a minimum of overhead expense, whereas the cost of operating one community clinic to handle such a patient load would be about $100,000 a year. Moreover, the service of a conventional clinic would be limited to a much smaller geographical area. A long-term plan for a state-wide program of this sort would suggest the desirability of having a small airplane available.

Northern State Hospital, Sedro-Woolley, Washington, experimented by bringing in prominent psychiatric teachers from distant metropolitan areas to spark training programs for its own staff. The hospital, which is situated in a beautiful vacation area, offers these teachers and their families a house (often vacant because regular staff members have gone on vacation elsewhere!) and a salary for a period of two to four weeks. In exchange the visiting professor spends a part of his time teaching in the hospital. This method could be tried by other state hospitals, geographically remote from training centers but pleasantly situated for vacations, to set up training programs for local general practitioners. With the resources of the new grant-in-aid program of the N.I.M.H. available to finance such projects, many other worthwhile programs can be developed.

One experiment has been tried in Pennsylvania which has produced such interesting results that plans are underway to develop the same thing on a permanent, state-wide basis. In this pilot project, a group of general practitioners were invited to a state hospital to attend a seminar to discuss the very patients they had originally referred to the hospital. The idea was to help these physicians to manage their own patients again after discharge. By confining the training program to actual case material already familiar to the physicians, it was possible to arouse in them an intense interest in practical psychiatry. They used the opportunity to discuss also the various other psychiatric problems they commonly meet in their office practice. This enabled the physicians to gain more practical knowledge than they could have gained from the usual kind of didactic lecture on the theory of psychiatry.

This raises the all-important question of what constitutes a reasonable kind of training program for general practitioners. It is suggested that when any hospital is planning such a training project, it first consult with its local medical societies, especially the District Branches of the A.P.A., and members and committees of the American Academy of General Practice. This will achieve three important objectives: (1) to stimulate interest in taking the planned course; (2) to ascertain what the physicians need, or think they need, in the way of psychiatric information; and (3) to make sure that the program is so structured that A.A.G.P. members can get training credit, which is an important incentive for them to take the course.

Clinical Material Is Best Teaching Medium

As in all other phases of medicine, psychiatry is best taught with the use of actual clinical material, and with a minimum of didactic lectures. Furthermore, the more the training program capitalizes on the actual experience which the students get, the greater the knowledge which can be imparted. To that end, it is suggested that general practitioner training programs make the greatest possible use of the trainees' own experience. This can be done by supervising their work with actual clinic or hospital patients, and by having them bring in their own case material. Above all, the general practitioner wants to know more about how a psychiatrist interviews a patient. This curiosity is a healthy one, for the technique of interviewing is the basic art of psychiatry.

Built into any brief training program for general practitioners must be a way in which the trainees can continue this postgraduate education. This might be done by offering periodic refresher courses or by inviting those who have taken the initial courses to sit in on hospital clinical staff conferences. Above all, it is important to make the most of person-to-person contacts which the general practitioner on the outside can feel free to use informally, to get help when he needs it. It would be advantageous to have an important staff member of each hospital responsible for building and maintaining these very valuable, though informal, personal relationships.

The General Practitioner Education Project is set up to assist mental hospitals and other training centers in the development of training programs for general practitioners. The project has a full-time staff located in the A.P.A. Central Office. This staff can assist in obtaining outside teachers for courses, and in planning and publicizing programs. It is wise to begin the planning of a course well in advance, because of the inevitable delays which result from conflict with other projects!

The Needs of Mental Patients

XI. Drive for Security

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"THE DRIVE FOR SECURITY," writes Barton, "expresses a conservative action to preserve the status quo. It . . . is based on the anticipation that situations may arise that would interfere with the satisfaction of other needs."

I think we can say, therefore, that we are not born with a sense of security or a drive for security. Both are acquired. We don't know how much security we will need until the whole system of checks and balances of forces is brought into operation upon demand. Security is not merely the absence of insecurity. Rather it is our wherewithal to withstand stress. It is the accounting of our total psychological transactions to date; it is an individual achievement. To build this inner security is a complex business reaching back into prenatal days.

The "sound body, sound mind" of the Greeks presupposes a healthy constitution as a basis for building a sound personality. Indeed some people seem to grow and develop more easily, smoothly and effortlessly than others. As physicians, one of our main jobs is to be sensitive to individual differences. There is no standard range for security as for blood pressure. It is far too complex.

The drive for security, as Barton points out, may be expressed in the field of economics or occupation, or reflect a need for love. It may also be expressed in various personal idiosyncrasies. Some people wear only suspenders, some belts, some both, some none. Some expansive manics stick their necks out and live dangerously. Some carry on with no hope of ever being happy. A depressed veteran in college, for instance, said he had given up all hope of passing any examination and of graduating, much less entering medical school. But he would stay there ten years or until they put him off the campus bodily. He said later it was pure instinctive cussedness that made him stick. He did go through medical school. Another person, similarly depressed, might actually have committed suicide.

Or again the drive for security finds various expressions in time of war or danger. When two soldiers were advancing with the infantry, one said to the other "What's the matter? You look pale and scared." The other replied, "If you were half as scared as I am, you'd be a mile in the rear." But in our industrial civilization, it is difficult for many people, short of war, to know what they can endure and how they stack up with their fellows in a showdown. To acquire a certain knowledge of one's potential is a part of the drive for inner security.

While it is important to consider individual differences in all things, it is also important to consider what we all have more or less in common. Eighty percent of the rank and file of soldiers in World War II had one thing in common—they held up in the service regardless of histories of broken homes, psychotic parents or alcoholic fathers. And David Rioch, reporting recently on several Korean War studies which predicted performance among recruits, isolated some common factors in the histories of soldiers who broke down with psychoses and those who did not.

Interpersonal Relations Reflect Individual Security

Six psychiatrists interviewed ninety recruits each, and they did a surprisingly good job in picking out not only those who would hold up, but also those who would break down. The one common factor in the history of those who subsequently made good was a rather pronounced religious background. Two things stood out strikingly in the histories of those who broke down. One was the I.Q. factor. The other was the behavior of the recruit during the formal interview. This demonstrates the importance of the business of relating oneself to another person; it is a very taxing matter to some, a very quickening experience for all. It reaches deep down into the inner security of the individual.

This sensitivity of human beings to one another has been measured quantitatively at Walter Reed Hospital in tests of autonomic nervous system responses. Soldiers hooked up with the encephalograph, blood pressure and vaso-motor recorders showed no more response when looking at Rorschach or TAT cards than when looking at neutral material. But as soon as the examiner put down the cards and started asking the soldier about himself—his name, rank, outfit or any question, personal or otherwise—pronounced autonomic nervous system responses were promptly registered in all leads.

Studies of soldiers who broke down in the service with frank psychoses revealed one significant common factor in their life histories—the way in which the families of these men had related themselves to the community as their children were growing up.

Further observations brought out other interpersonal factors which had affected the choice of symptoms in psychiatric disabilities. Each combat division had a tendency to develop its own special type of neurotic symptoms. The soldiers picked up the particular manifestations from one another. Here are valuable clues as to the important role that all human beings play in relation to each other's inner security.

We must now ask more about the nature of this drive for security. Is not security the capacity to cope successfully with our internal selves, our reactions, for instance, to our feelings, our successes, our failures, our angers,

resentments and sex drives—especially where other human beings are involved? I think it is. So in the final analysis, the drive for security is the urge to be self-reliant, to be in control of oneself, whether in making a living, visiting with people or playing for the fun of it.

We are fortunate indeed, if we are loved, wanted, cherished and accepted as we are, for richer, for poorer, in sickness and in health. Such acceptance can put a solid foundation under us, upon which we can build and learn the skills of coping with life, particularly with our fellow human beings. Sick or well, we have to make choices, persuade someone to change something, have the know-how to get ourselves out of jams when chances must be taken.

Admission Procedures Can Be Reassuring

It is natural to suppose that a person who needs to be admitted to a psychiatric hospital needs hospitalization by and large because he lacks an adequate sense of security. The doctor who refers him, the relative or sheriff who brings him, and the hospital admission officer who receives him can build up or tear down what little security the patient has managed to keep. Fooling him, or lying to him, even though he may at first desire such "protection," undermines his faith and trust in people at a time when he needs above all the security of honest as well as sympathetic dealing.

Once in the hospital, the fearful patient will be greatly reassured by a thorough, unhurried physical examination and the taking of his medical history. Proper respect for the body is the index of a good doctor, and tangible things are anchors in the storm. The patient is also reassured by the normal courteous procedure of introducing him as quickly as possible, not only to the staff, but to the other patients with whom he is to live. The hospital is a strange, and perhaps alarming place to one who is unfamiliar with it. The custom of putting each new patient on constant observation for 24 hours is considered by some personnel to be a chore, but seasoned nurses tell us that patients are grateful for what they consider protection from possible harm from others until they get acquainted and reassured. The first 24 hours are also a crucial time for setting the patient's attitudes towards the hospital and the personnel. It is not enough to give him a nice folder, outlining policies about visiting hours, restrictions, privileges and so on. It is much more reassuring to have a nurse explain carefully what is in this folder and to answer questions. "Tender, loving care"—the best possible way to help the patient maintain what security he has left—is, like the physical examination, a tangible act. It is smoothing out a bed, giving a back rub; it is sitting and spoon-feeding a tense, resistive patient instead of resorting prematurely to tube-feeding.

As the patient's feelings of insecurity begin to give way to allow him to resume more and more normal activities, his assurance will be greatly increased by the opportunity to speak his piece on a patient activity committee; he will feel much more the master of his fate if he can play a real part, however small, in planning the nature of the ward activities for himself and his fellows during the coming week.

Some patients, to recover their self-esteem, need the opportunity to be alone part of the time. This is difficult in an overcrowded hospital, but often some small area can be set aside for a music room or a quiet spot, so that a patient can sign up to use it to play the piano, listen to records, or just sit and watch guppies in a fish bowl.

All hospital personnel should keep in mind the average patient's fear of psychology. They regard it as something tricky and deceitful, an occult power that will enable somebody to master them. It used to be called "black magic." Now they term it "brain-washing." Whatever it is, it will see through them, undermine them and their faith in their most cherished beliefs. I don't believe the psychiatrist quite realizes how important it is that this fear be overcome before the patient can think of him as the good doctor, the dispenser of "good medicine," in the same way that he regards his family doctor. We should remember that fear and hope can both run riot in the presence of mental illness, which implies loss of health, loss of love, loss of caste and even loss of livelihood. The patient needs all the help he can get to teach him overcome his own ignorance and superstitions. And his family needs the same kind of help.

Family Insecurity Needs Treatment Too

Fear of the patient or the ex-patient can linger and lurk in his community to undermine his security long after he comes home. We know that people are unreasonably fearful of so-called insanity. Perhaps they are right, for it undermines their own sense of security. They have none of the usual guideposts or maps to show them where they are with such patients. Five courageous policemen will band together to bring one disturbed man to a hospital, whereas each officer singly would tackle a dangerous criminal. Public health officials, psychiatrists and general practitioners working together could do a lot to help dispel this unreasoning fear, which robs the patient and his family of their underlying feeling of security.

Treating the family with the patient is an important psychiatric team function today. Because of this there are fewer readmissions and more secure adjustments. The usual time to bring in the family is when the patient demonstrates his readiness for a showdown with himself and others. Some hospital administrators are adamant in holding that no patient should ever be released without a family conference, at which the patient and his family, as well as his doctor and social worker, are present. Several sessions may be needed before the patient and his family can speak up, come to grips with their true feelings and show the gains they have made in the direction of greater security and maturity.

The drive for security, is an ongoing process, by which we achieve, through struggle, a balancing of forces, a feeling of wholeness. This balance alone can give us tranquility, relaxation and refreshing spontaneity. As positive health is not merely the absence of disease, so security is not merely the absence of insecurity. It is an expression of harmonious functioning which frees the individual for greater creativity and for appreciation of the beauties of animate and inanimate nature about him.

INDUSTRIAL OCCUPATION

In Dutch and English Mental Hospitals

By E. CUNNINGHAM DAX, M.D., Chairman
Mental Hygiene Authority, Victoria, Australia

DURING my visits to European mental hospitals in 1957, I found that there is a growing tendency to believe that a patient in a mental hospital should be fully employed before he is given complete freedom; that full employment should be regarded as a preliminary to the discharge of the long-standing patients; and that a patient's chances of managing in the community are much better if he has been able to be fully employed in some industry within the hospital.

If these premises are allowed, then those of us in other countries must put our minds to the questions of how such industrialization can be implemented. How is the space in the mental hospitals to be made available? How are staff members to be induced to relinquish for industry some of the best workers in various hospital maintenance jobs? What is the first step in starting the industrialization, and how should we go about it? How can we communicate and demonstrate these principles to the mental hospital staffs? Who should be put in charge of the industries?

From a strictly economic standpoint, no state or country can afford to have a vast potential labor force unoccupied, doing half a day's work on hospital industries, or making decorative and not very useful objects in the occupational therapy departments. Despite this, except in Holland, industrial work for psychiatric patients was only slightly developed in the countries I visited.

Twenty five years or so ago there was a general change in the treatment of the mentally ill as the result of the introduction of the physical therapies. At the present time there are no less revolutionary changes taking place through the use of the tranquilizers, or "socializers" as it might be more appropriate to call these drugs in mental hospital practice. This is not because they are an end in themselves, but because they have been the means of aiding social therapy and occupational activities, which in their turn have resulted in the complete freedom and rehabilitation of many long-standing patients, particularly in the English hospitals.

Editor's Note: Dr. Dax, who will be well remembered by those who attended the Ninth Mental Hospital Institute in Cleveland last year, describes a type of "industrial therapy" practically unknown in this country. Where he speaks of "industry" in the hospital, he refers, not to the various hospital maintenance service or housekeeping jobs with which patients in North American hospitals are generally occupied, but to a program in which patients actually produce, on a contract basis, certain items which are bought by manufacturers. Patients receive payment for their work, although the hospital may have to to take a small proportion in order to support the program.

"Industrial Work" a New Hospital Program

Occupational Therapy is of particular value to these long-standing patients whom the drugs have made accessible, in retraining them to work either in groups or as individuals, and giving them a sense of positive achievement. But the craft work traditionally done in occupational therapy shops is a hobby, and can properly be done in the patients' spare time, just as hobbies are a spare-time occupation for people in the community.

But the industrial work which has attained so high a degree of efficiency in the Dutch institutions and which I also saw developing in some mental hospitals elsewhere would be regarded in most places as a new type of program. By industrial work is meant a type of factory production for which payment is made.

Ongoing Programs in English Hospitals

In England I revisited Warwick and saw the remarkable results of an experiment which began in 1949. At that time about 100 male and 100 female unemployed disturbed patients were segregated into two separate buildings with five nurses in charge of each building. I was there quite soon after the project started, and saw how very disturbed and restless these patients were. On my 1957 visit the complexion had completely changed. The patients were quiet, well occupied and needed little supervision. On the female side they were doing papier mâché work, teasing cloth, sorting wool, knitting, making dish cloths, arranging shells, working on looms, making washing flannels and kettle holders, decorating fir cones, constructing wool rugs and repairing clothes.

On the male side they were occupied by making lampshades, rugs, stools, repairing furniture, wool sorting, repairing bowling pins, making ash trays, candlesticks, mops, dinner trays, leather goods and electrical fittings. Some recent industrial work on dismantling old post office telephones had begun. The Physician-Superin-

tendent, Dr. E. S. Stern, believes the patients should, if possible, do a job before they leave the hospital, as relatives and the patients themselves then feel more confident of employment on their return home. There is much enthusiasm about this work and the freedom which can be given in this open hospital and which is largely due to the full occupational program; it is believed here that the long term patients in the past were made chronic by the institution rather than by their illness.

Netherne Hospital too has an excellent industrial setting within the artisan shops that I saw, and a concerted effort is made to rehabilitate the patients through the hospital industries. Of special interest are the printing shop which employs 40 patients; the building department which is now building its third occupational therapy workshop in brick and concrete; the concrete construction unit and the paint spray shop.

At Banstead the industries are more highly developed than in the other mental hospitals I saw in England. The Physician-Superintendent, Dr. E. P. H. Charlton, is most optimistic about the results, particularly in relation to the resocializing of the patients which is enabling them to be discharged and preparing them for full industrial activity. The Social Psychiatry Research Unit of the Medical Research Council is conducting some interesting research to find out how well the patients can work, what will persuade them to be occupied and what incentives can be used for suspicious, uncooperative patients. Inquiries have also been made about patients discharged after more than two years in the hospital. Two-thirds of them have been successfully absorbed into employment.

Amongst the industries at this hospital are the making of cardboard boxes, packaging motor-car parts and packing Christmas stockings. Other patients are employed winding fishing lines, assembling car lights and oil pumps, painting and wrapping clutch plates. Destructive patients are kept occupied by tearing paper for packing; lampshade making, napkin folding and chocolate packing are other examples of industrial projects. Regressed patients are in the charge of nurses; the others have one instructor to twenty-five patients, the same proportion as followed in the Dutch industries. I found this proportion of staff to patients almost identical everywhere, with each hospital seeming to have arrived at the optimum of 1 to 25 independently.

Dutch Hospitals Have Active Programs

In Holland I visited five mental hospitals and in every one of them found intense activity in the industrial field. Large workshops are given over to this purpose: St. Willibrordus Stichting at Heiloo has no less than six large occupational halls grouped together. The working hours are longer in Holland hospitals than elsewhere and the patients attend the departments from 8-12:30 and 1:30 to 5, working a 44½ hour week as against, for instance, 25 to 28 hours in England.

Amongst the many occupations seen were bookbinding, box-making, knitting, sewing, wire-stripping, making television clips and assembling TV and wireless parts, repairing bulb and fruit boxes, making and packing clothes pegs, making waste-paper baskets, rug-making, telephone demolition, sewing buttons on cards, picking rubber offcuts for pillows and making flower baskets. At one hospital there was a test room to see what the patient preferred before he was assigned to work in one of the industrial departments. Throughout the hospitals the most popular industry was making rope mats, often in colors, by winding the rope in and out of steel uprights and beating it down, then inserting cross supports. This produces very tough and popular doormats.

Programs Used for Mental Defectives

Some of the most remarkable work I saw was done by mental defectives. At Darenth Park Hospital in England many of the patients are high-grade defectives, and 150 of the best workers go out to employment each day, in the nearby town. The organization of the industries is excellent.

The various occupations are well apportioned according to the patients' capabilities. The lowest grade female patients were sorting materials, making dish-cloths and string bags. The male patients assemble deck chairs, step ladders, toys, stools, tables, tear paper for packing and make envelopes. The higher-grade boys and some girls were involved in cardboard box construction, making envelopes with cellophane windows and wiring and assembling electronic organs. Filing and polishing plastic castings, making cables and attaching plugs, making paper clips, demolishing old armatures and telephones and making spring mattresses are other activities for the men. The women are employed in making night attire, sheets, pillowslips, tea towels, coarse aprons, socks and mats, and in performing domestic tasks in the hospital. The work was all proceeding very smoothly; the patients were having tea and Coca Cola and listening to music while they worked.

There is a training school at Darenth for the lowest grades of patients and for the physically handicapped workers, who move on to the workshops when they become competent enough; some never reach this level.

In Holland at Noordwijk the patients belong to so low a grade of the intellectually defective as to be normally regarded as unemployable. But here they are doing the most remarkable things: stripping and cleaning cable wires; making cardboard boxes and packing them with soap; constructing leather buttons and attaching them to cards; making and labeling blackboard cleaners, weaving towels and tablecloths and rugs. The patients doing these tasks are certainly of no higher intelligence than those mongols in our Australian day centers and some are lower. The hospital makes between $2,000 and $2,500 per year profit in this way. I saw somewhat similar patients making rope mats at Den Dolder Hospital.

A Dutch Sheltered Workshop

One of the most impressive of all the occupational units visited was that at The Hague. This is a sheltered workshop to which patients come by the day—Mr. Menzelaar, the Director, has many ingenious ideas for using the patients' activities, inventing apparatus for them to use, and interesting them in their work. The staff has a profound understanding of the patients' capabilities and

how to get the best out of them. The Director makes a point of studying each kind of work he brings in before it is given to the patients. There is an insurance scheme for the workers and much study has been given to the best way to pay them. There were a vast number of occupations proceeding; two separate workshops employed 330 patients, who are a mixture of equal numbers of intellectually defective and psychotic patients. They were all living either at home or in hostels. About 15% of the patients who have attended have been able to return to industry. In this case one instructor looks after about 40 patients. Many of them are nurse instructors who have come to this work from the mental hospitals. Two or three inspectors and finishers from industrial firms inspect the final products. Among the many activities are the making and fitting of canvas tops to rubber soled shoes and finishing them, putting in laces, making the boxes, packing and labeling them. Eleven hundred of these are completed each day. Vacuum cleaner tubes are prepared. Rubber rings are mounted on paper, fifty at a time by a mongol who cannot count or write but who uses a counting device. Cardboard boxes were made, paper glued on the boxes and then finished. When I was there, the moving band supplying the production line was being controlled by a mongol! Twelve hundred of these boxes are made daily. Television units are assembled, also vibrator transformers which are packed and shipped directly to Africa. Radio parts are put together, stamps removed for sale to philatelists, radio cables cut, cleaned and attached to fittings, measured, dipped, silvered, fitted and piled. Vacuum cleaner sacks are made by machine, and two girls produce 2500 per week. Mongols were working on electric machines for making blouses and on rope mat making.

A somewhat similar workshop in Amsterdam follows rather the same activities and also makes many baskets. Here again the hours of work are from 8:30 a.m. to 5 p.m. In conjunction with this workshop there is an agricultural project which is not yet fully underway. Here fifty-five psychotics and intellectual defectives raise flowers, vegetables, fruit and eggs for sale. The buildings are excellent and several greenhouses are looked after by these patients. In addition some 15 patients are used by the local authority as street cleaners.

Neither the workshop at The Hague nor the day center at Amsterdam makes a profit; in fact it costs from about $85-$210.* a year to keep each patient there. However, even this is considered a very profitable investment, for otherwise many of these patients would have (a) returned to the hospital (b) been in trouble with the community or (c) immobilized active members of their families to look after them.

Some Problems to Be Faced

To set up satisfactory programs help is required from all who have common interests in industrial rehabilita-

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* *Based on Sterling rate $2.80 = £1.*

tion. The problem everywhere seems to be to obtain sufficient suitable and continuous work to keep the patients occupied. In each instance it has been advisable to have some side product to which the patients could revert when unoccupied with the main work, or where there is a lull in supplies. There is in every case a need for a staff member to contact the industries concerned, to arrange for supplies and deliveries, to supervise the timing and program the work. There seems to be more difficulty in finding suitable industrial activities than should be the case; and in every hospital it was said that the work is apt to be sporadic and to take a considerable effort to find.

If, however, it is agreed that the most satisfactory means of rehabilitation is to begin to employ the patients as soon as possible on some industrial undertaking, a number of problems must be faced and overcome.

(1) If patients are to be gainfully employed within the mental hospital, the matter must be approved in detail by the appropriate trade unions. The unions could ideally take a part in the patients' rehabilitation, which should be equally aided by manufacturers.

(2) Some adequate form of payment to the patients must be worked out. The hospital must usually take some of the earnings for overhead. In one of the most satisfactory methods I saw, the hospital paid all the working patients a flat rate weekly. The money actually received was divided up to allow further sums to be given to particularly productive patients. Any money left over then went into the hospital funds to provide luxuries such as, for instance, curtains, wireless and television sets, for the benefit of all the patients.

(3) Patients must not be kept in the hospital to increase production, although their full and useful employment is the first consideration. After this has been attained, their discharge must be regarded as far more important than the industrial activities which are used as a means to this end.

(4) The industries should be carried on in close cooperation with the government department of labor and with the assistance of the hospital's social service department.

The movement towards industrialization within mental hospitals is beginning to be established and will, I believe, grow. Occupational activities will need to be modified in consequence and it is likely that these alterations will result in considerable changes for the better in mental hospital rehabilitation.

Everybody Happy?

By DR. WHATSISNAME

SINCE he is a psychiatrist as well as an administrator, the mental hospital superintendent ought to be a double-barreled expert in personnel relations. He should know just how to handle employees, keep up morale and provide gratifications for everybody. But, of course, employees in mental hospitals do not have any higher happiness quotient—or morale quotient—than employees in law offices, department stores, or amusement parks.

There are, in the first place, the obvious frustrations: low salaries, off-side locations and slow promotion. Then, too, the superintendent's greater psychiatric knowledge is no guarantee that he can make everybody happy.

One might, indeed, argue that if every employee were always happy, the administrator should have his head examined. In any large organization there will be situations where employee A wants blue and employee B wants white, and it is impossible to satisfy both. If the superintendent keeps his door open to every employee, he has to adjudicate trivial complaints, often without consulting the intermediate supervisors. If he insists that employees go through channels, he gets himself branded as a bureaucrat. If he has taken a course in "human relations" he has been told that the way to keep up high morale is to make all decisions by conference so that each employee feels he has a say. But if he actually does that, he will have to bulldoze the more articulate and original employees into silence—otherwise he could never get the agreement which is supposed to be so precious. The stubborn and foolish will not yield, whereas the wise and sophisticated will. They don't think it's worth getting ulcers over. Result: a victory for the stubborn and foolish.

Of course, there will always be superintendents who reject the system of decision by conference. They listen to staff advice, but make crisp decisions and take responsibility for them. This may be undemocratic, and the human relations experts may protest that it frustrates members of "the team." But—though it may not leave everybody happy—at least it gets things done.

1958 Mental Hospital Service Achievement Awards

NEBRASKA PSYCHIATRIC INSTITUTE, OMAHA

Director: Dr. Cecil Wittson

CITATION: Nebraska's decision to invest in a psychiatric research and training facility, rather than just adding more hospital beds, has paid dividends in a dynamic program that has benefited the entire state and also aids the Dakotas and Iowa.

A prominent educator once expressed his feelings about the importance of medical research thus: "If I were standing on the banks of a swift river and a drowning man came struggling past, I'd jump in and save him. If then another came by, I'd jump in and save him too. But when a third and fourth and fifth appeared, I'd want to go upstream and see who is throwing them in."

Similarly, when Nebraska was confronted with the task of meeting the needs of its mentally ill, the legislature faced the problem realistically and decided to "go upstream." The sum of $1,500,000 was appropriated to construct a psychiatric research and training institute on the campus of the University of Nebraska College of Medicine. Legislation was passed enabling the State Board of Control and the University's Board of Regents to unite, for operational purposes, the state psychiatric facilities with the College of Medicine. Through this arrangement, the functions of the institute would be much broader than those of the usual university psychiatric division. By coordinating its programs with those of existing teaching and treatment services and by mobilizing community resources, the institute could give leadership to an effective statewide mental health program.

The new Nebraska Psychiatric Institute was opened in May 1955. In order to facilitate exchange between hospitals and university, the Chairman of the Department of Neurology and Psychiatry of the medical school and Director of the Institute, Dr. Cecil Wittson, was also appointed director of the state's mental health program.

In its educational programs the Institute has concentrated on meeting the state hospitals' needs for professional personnel. The problem is no longer one of recruiting psychiatric residents but of selecting from candidates. The majority of the current trainees will join the staffs of the state hospitals, which now expect to fill all their professional positions within five years.

All but one of the new psychiatric residents appointed were graduated from the University of Nebraska College of Medicine. While attracting young physicians to psychiatry is a patent aim of the Institute's undergraduate psychiatric teaching, an equally important one is to prepare those who enter other specialties or general practice to deal with any psychiatric problems they might encounter.

Psychiatric training is also given at the Institute to psychologists, social workers, nurses, ancillary therapists and other disciplines connected with the field. Special courses, such as postgraduate seminars for general practitioners, orientation courses for clergymen and nursing education workshops, are given from time to time.

Several procedures evolved for training are innovations. Particularly noteworthy are the closed-circuit television system* and the telecommunication network.** The latter links the Institute with the Nebraska State Hospitals and with institutions in North Dakota, South Dakota, and Iowa. It enables these institutions to participate in the lectures and conferences held at the Institute, and to consult with specialists at the University on clinical and administrative problems.

A year after its opening the Institute inaugurated a Research Division. With continuing funds earmarked by the state—the first medical research appropriation ever made by the Nebraska Legislature—and grants from public and private foundations, both basic and clinical studies are conducted. Half of the work is carried on in two of the state hospitals, where research units are set up with personnel and equipment supplied by the Institute.

In addition to their own studies, the Institute and the hospitals cooperate with other departments of the College of Medicine in coordinated research projects. Federal and private funds were recently obtained to construct a research pavilion at the Institute. One floor of the new pavilion will be devoted to research in mental deficiency, seeking more effective diagnostic and treatment procedures.

Another important component of the Nebraska Psychiatric Institute is the Community Services Division. Its

Note—See Mental Hospital Institute Story on p. 28.

* *See MENTAL HOSPITALS, November 1956.*
** *Ibid., January, 1957.*

mission is to extend psychiatric services to the outlying parts of the state, for all three state hospitals are on the eastern border, within 150 miles of Omaha. The division has established area mental health units, outpatient and traveling clinics. It also offers consultation and conducts a multitude of public education activities. One of the division's special interests is rural psychiatry, and two pilot projects are underway to investigate means of meeting the psychiatric needs of rural communities.

During the past three years the Nebraska Psychiatric Institute has more than fulfilled initial expectations. It has, in effect, extended the medical school campus to all areas of the state. The state hospitals and outlying areas have benefited from projects initiated by the Institute and in turn have enlarged the scope of clinical material available to the medical school. In addition, the Institute's senior faculty serve as a "central office" staff of specialist-consultants which the state could not otherwise have obtained or afforded.

Honorable Mention

Minnesota Department of Public Welfare, St. Paul

Medical Director: Dr. Dale C. Cameron

CITATION: Taking advantage of the public concern which had arisen about state hospitals during the "Fomenting Forties," Minnesota set up the first statewide program to give direction to the efforts of willing citizens who volunteered their services to its mental institutions.

The late forties were significant years in mental hospital history. People were made aware, by newspaper and magazine stories, of the deplorable conditions prevailing in state mental hospitals and were moved to see that corrective steps were taken. Most worked indirectly, through their legislators, but many wanted to give personal aid. In Minnesota the number of citizens who offered their services to the state hospitals had, by 1952, reached sizable proportions. The state recognized that it had here a valuable reservoir of assistance. To be of maximum use, however, these voluntary efforts must be directed, coordinated, encouraged, developed.

Thus it was that in 1952 Minnesota appointed a State Coordinator of Volunteer Services—the first such position in the country to be established with state funds. The coordinator inaugurated her program by developing administrative tools and guides which dealt with orientation courses, award ceremonies, record keeping, and similar devices to help the hospitals make the most effective use of volunteers.

With the hospitals better prepared to utilize voluntary services, the next step was to recruit more citizens to serve. A major aid in this drive was a booklet, "Volunteers in Minnesota's State Hospitals," which outlines what volunteers can do. This booklet is still in use and has been copied by several other states. Minnesota's newest recruiting device is a film. "The Human Side," released last year. It shows how volunteers function in a mental hospital, how they are trained and what they contribute. Volunteers themselves helped make the film. The roles of patients and volunteers were played by 122 volunteers at the Willmar State Hospital.

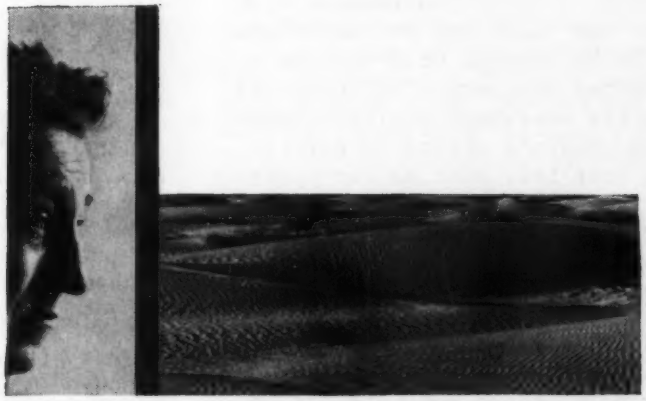
The success of these recruiting efforts is particularly remarkable in view of the fact that many of the hospitals are located in sparsely settled areas where travel is often difficult. Despite the geographical drawbacks, several thousand Minnesotans give regular volunteer service and every year more than 10,000 people, mostly in groups, bring special entertainment programs to the hospitals. A large number of individuals and organizations also contribute materials and equipment for patient programs. Six of the eight state hospitals now have full-time volunteer coordinators.

Since 1955 the state coordinator's efforts have been augmented by those of the Voluntary Advisory Committee, made up of qualified professional people who work with volunteers. This committee helps develop policies and makes recommendations for expanding and improving volunteer services in the state hospitals, concerning itself with such matters as orientation, awards, administrative procedures and community liaison. As a result of one of the committee's recommendations, a statewide survey of leisure time agencies was undertaken to learn which ones would welcome former hospital patients into their activities. The resulting information, published in booklet form, is available to county and hospital social workers to assist them in making post-hospital plans for patients.

The Volunteer Advisory Committee also recommended extending volunteer services to communities throughout the state. This is to be done through the 87 County Welfare Boards, which act as the official follow-up agencies for patients discharged from the state mental hospitals. St. Louis County has already started such a program. The county has hired a coordinator who directs the activities of nearly 50 volunteers working in the community with aged, blind, and disabled persons as well as with former mental patients. Ten other counties are interested in starting a similar plan. The State Welfare Department's coordinator of volunteers acts as a consultant to the boards in developing their programs.

Another group which actively assists the state volunteer coordinator is the State Volunteer Council. Composed of representatives of some 30 statewide organizations and agencies, it offers a means of exchanging information and ideas and of activating new projects. Through the work of the council, the state chapter of

WHEN
A MAN IS A
DESERT...
FILL THE
EMOTIONAL
VOID



The sterile negativism of the schizophrenic, the paranoid and the senile can be reversed, as Pacatal helps restore more normal patterns of emotional response. Contact with withdrawn patients may be quickly re-established.[1-3]

PACATAL • "normalizes" thinking and emotional responses
• calms without "flattening"—keeps patients alert
• elevates the mood instead of sedating the patient*

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References
1. Braun, M.: Am. J. Psychiat. *113*:838 (March) 1957. 2. Feldman, P. E.: Am. J. Psychiat. *114*:143 (Aug.) 1957. 3. Hutchinson, J. T.: Paper presented, American Psychiatric Association, Philadelphia, Pa., November 16, 1956.

FOR NORMALIZATION—NOT SEDATION **Pacatal®**
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WARNER-CHILCOTT

the American Association of University Women has undertaken a two-year survey of the job and home-finding needs of discharged mental hospital patients and of community attitudes toward meeting these needs. Several other organizations represented on the council are preparing a questionnaire to ascertain how effective mental health education efforts have been. The questionnaire will be distributed to several thousand club members in Minnesota and is expected to yield data of use to anyone planning public education strategy.

Honorable Mention

New Jersey Neuro-Psychiatric Institute, Princeton

Medical Director: Dr. Robert E. Bennett

CITATION: Since its conversion in 1952 from an "ideally isolated" colony for epileptics, the institution has developed rehabilitation and family care programs which have enabled over one fourth of its patients to leave the hospital.

Memo to: Dr. Garber
From: Lillian L. Cole, Director of
Psychiatric Social Service
Re: Placements

December 3, 1957

In the past two years 180 patients have been placed after average stay here 25 years. 45% earned discharge. 35% returned, the majority for prolonged medical attention which we couldn't afford to pay for in a general hospital, such as for fractures and surgery.

Some go home but most go on Family Care. They write to patients still here in such glowing terms we are pestered--all our patients want to leave. We have no problem finding good homes for our patients. Seldom a week passes that we don't receive a letter offering to board patients for us (and at $3.00 a day it is not a money-making idea).

Some go on jobs--probably live-in jobs at first. The patients make steady, reliable, careful workers. The hardest part is to "sell" an employer on the idea of hiring an epileptic. Once sold, they call us when they expect a position to become available. Antoinette and Mary, for instance, both of whom came here as teenagers and are now in their 40's have done so well as domestics that we have many requests for girls just like them.

Placement program is so successful we have difficulty keeping within our annual appropriation of $60,000.

* * * * *

For the first 55 years of its sixty-year existence, the New Jersey state institution at Skillman (the site chosen, a "1200 acre farm ideally isolated") functioned as a custodial haven for epileptic persons. In 1952 the legislature changed the name of the institution to the New Jersey Neuro-Psychiatric Institute and broadened the scope of its endeavors.

Faced with the task of converting a 1500-bed custodial institution into a psychiatric and neurological treatment center, Dr. Robert S. Garber, then Medical Director, gave priority to reorienting the existing personnel corps and to building up the professional staff. Training programs for residents, theological students, social workers and technicians served to attract qualified personnel.

With the help of newly-developed anti-convulsive drugs, an active medical regimen was put into effect. First, however, the entire patient population was reclassified according to the A.P.A. Diagnostic and Statistical Manual. The psychiatric evaluation showed that nearly half of the 1260 patients were psychotic, a third were mentally defective, and 89 patients had no mental disorder. Some patients were found to be neither epileptic nor mentally abnormal; these included several children who had diabetic convulsions, a woman who had suffered one convulsion as a result of eclampsia, and two patients who had spent nearly 50 years in the institution but had never had a seizure.

Along with progressive medical and psychiatric treatment, improvements and additions to the physcial plant and equipment, and administrative reforms, the Institute initiated rehabilitation programs to prepare the patients for discharge. Group psychotherapy and carefully planned industrial training proved especially valuable.

By 1955 most of the patients who were well enough were returned to their families—after social service had paved the way. For others the hospital found live-in jobs. There still remained the problem of placing those patients who had no suitable homes to go to. For these patients the Family Care Program was developed.

Many considerations went into making the program a success. Homes had to be found and evaluated. At first there was competition with other placement agencies, which were seeking homes for dependent children, aged persons and the like; in time a cooperative procedure was worked out which has been mutually beneficial.

The Social Service Department had to prepare not only those who would give the family care but those who would receive it. Sometimes it took much gentle en-

couragement before a patient was willing to leave the familiar hospital setting to live among strangers. Then he had to be taught how to cope with such everyday matters as traffic lights, public transportation and telephones. Once the patients were placed, the social workers would visit them as often as necessary to ease the transition period. All efforts were directed toward bolstering the patients' self-sufficiency and equipping them for eventual discharge.

The hospital now finds itself with an abundance of homes which will accept Family Care patients and with at least 70 patients who are ready for placement, but without enough funds to match supply with demand. The $60,000 annual appropriation which at first was more than ample now fails to keep up with the Institute's success in preparing patients for living outside the hospital. Some of the problem is solved, however, when Family Care patients are able to take jobs or become eligible for old age or disability assistance.

Since July, 1952, 421 patients have been placed in the community, and over half of them have been discharged. Nearly 200 of them had spent an average of 20 years in the hospital; some oldsters, in fact, had been hospitalized for nearly a half-century.

Honorable Mention

Osawatomie State Hospital, Kansas

Superintendent: Dr. George Zubowicz

CITATION: Before initiating a campaign to win community interest and support, the Osawatomie State Hospital had to open up channels of communication within the hospital. Better internal relations helped the hospital achieve good public relations.

Osawatomie State Hospital, located near the Kansas-Missouri border, serves twenty-two counties in Kansas, some a considerable distance away. In order to keep the citizens of these counties informed of and interested in its programs, the hospital had to devise vigorous means of communication—just as a radio station must boost its power in order to transmit to a wide area.

Since good public relations begin at home, the first move was to step up the flow of information within the hospital. Under the direction of a newly appointed public information officer, a *Daily Bulletin* was started to inform all employees of changes in policies, schedules and personnel. A public address system was installed so that announcements could be quickly relayed throughout the hospital.

Committees were formed to present to management the staff's views on such matters as recreation and safety; such recommendations are usually incorporated into hospital policy. Another medium devised for upward communication is a weekly meeting for supervisory personnel. These meetings provide a regular forum for the exchange of information and ideas among departments and also serve to influence policy decisions.

With its internal relationships strengthened, the hospital set out to cultivate the good will of the community. The Kansas University Extension Division was requested to come into the hospital and conduct classes in supervisory skills. These classes, for which graduate credit is given, are open to the public; about half of the present students are teachers and social workers from the Osawatomie area. Also of local import is the hospital page which appears regularly in the weekly community newspaper, the *Osawatomie Graphic News*, which has a circulation of 5,000. Through it the local citizenry is kept acquainted with the hospital's activities.

To reach outlying communities, the public information officer periodically sends news releases to 91 newspapers in the hospital's 22-county district, giving details about developments of particular interest to the different circulation areas. Stories which have a broad appeal are released nationally through the wire services. (As a check on which releases are published, the hospital subscribes to a news clipping service.)

Radio and television are used whenever suitable. Osawatomie staff members have appeared on mental health programs televised from Kansas City and Topeka, and on occasion the stations have presented announcements illustrated by slide-films about the hospital.

While publicity plays a large part in the hospital's scheme to make its resources and needs known to the public, personal contact is considered equally important. The public information office acts as a speakers' and visitors' bureau; it arranges for staff members to address outside meetings and provides them with reference material and visual aids. Professional and civic organizations are invited to hold meetings at the hospital, student and club groups are encouraged to tour the institution. The office also prepares exhibits which are displayed at professional meetings outside as well as inside the hospital.

Good community relations have emerged as by-products of several other operations. The volunteer program is, of course, a prime source of good will ambassadors. Another is the training program for nursing home administrators. Each month the hospital gives instruction in the care of the aged for the nursing home operators. To reinforce the good will engendered by this plan, the public information officer sends each trainee a clipping of the write-up and class photograph which are published on the hospital page of the *Graphic News*. She also sends a news release to the home town newspaper of each trainee.

The Modern Founders' Room

Named to honor those who contributed $500 or more to the Building Fund, the library is to contain the "Autograph Library" of members' books, and paintings of the "original thirteen" founders of the Association.

Immediately adjoining the library is the Officers' Room, which permits the President and other visiting Association officials privacy for work or interviews during their visits to the Central Office.

A.P.A. CENTRAL OFFICE DEDICATED

THE FORMAL DEDICATION of the new Central Office of the American Psychiatric Association took place in the Century Club Room on October 31st, 1958, in the presence of 200 officers and committee chairman of the A.P.A., and distinguished guests. The Honorable Arthur S. Flemming, Secretary of the U. S. Department of Health, Education and Welfare, honored the 118-year-old Association by giving the Dedicatory Address.

The ceremony was followed by an "open house" and reception for A.P.A. members and friends. Some 300 to 500 people visited the building during the evening.

The Georgian-style town house was bought and renovated through the generous support of A.P.A. members. Although the total investment approaches $300,000, it has not been necessary to resort to a mortgage or other loan financing either for purchase or renovation.

The Century Club Room

This ground-floor conference room was named in recognition of A.P.A. members who each contributed $100 to the Building Fund. The Dedication ceremony was held in this room, which is used for receptions and meetings.

The third and fourth floors are devoted entirely to offices. Private office space is available, in addition to large rooms used variously as editorial offices, typing pools and general office space.

"Man, the marvellous thing, that in the dark works with his little strength to make a light"—MASEFIELD

Magazine Reviews

The mental illnesses of old age continue to receive much attention, but probably—in common with all mental illness—not as much as is needed. Progress is being made, however, and some of the problems are being more clearly defined with the result that more positive treatment programs are developing. An excellent symposium is contained in GERIATRICS (February 1957). It is opened by Dr. Kurt Wolff with a review of the literature and a discussion of various aspects of the aging process, most of which need further study. He then attempts to define which patients should be cared for in mental hospitals and which should be cared for otherwise. Such a definition is urgently needed but extremely difficult to make. A great deal of discussion is necessary before we can ever hope to define a policy which will be generally acceptable.

In the same symposium, Dr. Otto L. Bettag points out that since 1920 the number of people over 65 years of age in Illinois has increased two and one-half times. During the same period this same age group in the Illinois mental hospitals has increased four times.

Perhaps a better way may be found to care for these elderly patients but there can be little doubt that the state mental hospital is going to bear the major responsibility for many years to come. We have no choice but to accept that responsibility and to do all in our power to provide proper care.

Another important study in this area is the report of the Conference on the Problems of the Aging in New York State. The report is entitled "Charter for Aging" and can be obtained from the office of the Special Assistant, Problems of the Aging, State Capitol, Albany, N.Y. ($3.00). This report is a summarization of the thinking and experience of leaders who have made a careful study of many facets of the aging process. Especially pertinent to our field is the section on Mental Health.

General Hospitals Expand Psychiatric Care

Provisions for psychiatric care in general hospitals continue to expand. Each new facility approaches the project in its own individual way, governed apparently by the local conditions and by the beliefs and experience of the people involved. Those of us who are primarily concerned with mental hospitals need to keep informed about these developments in the general hospital field. It now seems that the general hospital is going to have an increasing role in the care of acute psychiatric problems and we need to bear this in mind when planning for the future of mental hospitals. In the May 1958 MODERN HOSPITAL, Dr. James Glotfelty discusses the psychiatric service in a Veterans Administration general hospital. The August 1958 issue of the same journal describes the psychiatric unit of the St. Francis Hospital in San Francisco.

One of the trends of the past few years which impresses me is the use of illustrated reports of what is taking place in mental hospitals. Such reports that I have seen have been excellent and should do much toward broadening the understanding in the community. The dry, statistical report has a place but is read only by those who have a very special interest. I hope that the trend toward illustrated reports will expand.

The journals which are primarily designed for the general hospital seem to be carrying more articles which have direct application to mental hospitals. INSTITUTIONS (June 1957) has an excellent summary of recent advances in food preservation and storage. Items considered include canning, dehydration, dehydro-freezing, antibiotics and radiation. MODERN HOSPITAL (March 1957) has an article on state hospital laundries by Richard Spirling of the Fairfield (Conn.) State Hospital. This article calls attention to recent developments in laundry equipment and should be helpful in planning improvements. Mr. Spirling also comments on the value of a dry cleaning unit. (At our hospital, we have preferred to send the dry cleaning out on a contract basis rather than install and operate a unit of our own.)

An arrangement which seems most realistic to me is the food service at the Butler Mental Health Center in Providence. They have a contract with a catering service which hires and trains the personnel, buys, prepares and serves the food. As Dr. Hyde says, "The food service is provided by people who are in the food business."

Higher Costs Necessitate Efficiency Measures

The increasing costs of operation make it imperative that we be alert to all measures which will increase efficiency. It is going to cost most of us more money before we can feel that we are doing a reasonable job in the treatment and rehabilitation of our patients. The legislators will understand business and maintenance expenses more easily than medical ones and unless we can show that the former are conducted in an efficient manner we are handicapped in asking for funds for the main purposes. Labor saving improvements are now available in nearly all departments; farm, laundry, offices, etc. Some of these, such as copying methods, microfilming of records, systems for statistical analysis and electric typewriters, are now practically standard equipment. One recent development which we hope to install is a radio paging system. This should speed calls and also help in public relations. Anxious relatives are apt to become quite impatient while waiting for the telephone operator to locate the doctor.

RUPERT A. CHITTICK, M.D.

Film Reviews

An interesting feature of the Tenth Mental Hospital Institute was the premiere of A NEW CHAPTER, a film designed for use with discussion groups of patients. A review of this 30-minute film appears below. Although the film will not be added to the Mental Hospital Service Film Library, it is available to mental hospitals through Smith Kline & French representatives.

A NEW CHAPTER (30 min., black-and-white, sound)

On the day that Ben Wheeler is discharged from the mental hospital, a new chapter begins in his life. The hospital psychiatrist assures Ben that he is now well enough to get along on the outside and reminds him that

there are people in his community who can give him help if he feels that he needs it. Ben's younger brother, Frank, takes him home. Although Frank is genuinely glad to see that Ben is well again, there is some uneasiness in his manner. Throughout most of the film, we are made aware of the conflict between Frank's fear of mental illness and his honest desire to believe in his brother's recovery.

The film dramatically presents the minor irritations resulting from the brother's over-protectiveness. But there are other experiences with friends which help to bolster Ben's confidence. There is, however, still one great hurdle for the former patient—he must get a job. Afraid that no one will hire him when they learn that he has been in a mental hospital for the past three years, Ben finally decides to seek some help and talk things over with his family doctor, who is comforting but also insistent that he go out and try to find work. Ben takes this advice, but fails to get the first job he tries for. On his way out of the office, he meets another rejected applicant. This man, who is keenly disappointed, tells Ben that he intends to try another lead. Pausing to reflect a moment, the former patient gets some insight. The thing he had feared most has happened, yet he feels unchanged by this experience. He is really no different from that other man, whose disappointment equalled his own. With his fear of being different gone, Ben sets out to find his job.

Produced by Dynamic Films for the Mental Health Education Unit of Smith Kline & French Laboratories, with an impressive list of psychiatric advisors, A NEW CHAPTER is a professional job of film-making. Illumined by the acting of Pat Hingle as the former patient, Howard Rodman's script is sensitive and occasionally moving. The producer's stated intent in making this film was to provide a discussion tool for hospitals to use in preparing patients for their return to the community. The exact use of the film will undoubtedly vary from hospital to hospital; some superintendents will use it with patients before discharge, while others may prefer to use it with patients after they have left the hospital.

The film is intended to motivate the patient to seek out and make use of the aftercare services available in his community. Although the dialogue contains references to "clinics," "social workers" and "rehabilitation counselors," the film actually shows only one resource: the patient's family doctor. There is, however, a discussion guide provided with the film which will help discussion leaders to bring in the other facilities—if these facilities exist in their particular community.

The film will also be useful to hospitals conducting group psychotherapy sessions with patients before discharge. Used as illustrative material in such a setting, it should help the patient to handle his feelings about his imminent discharge.

Still another use of the film would be with the lay public: with relatives and friends of patients, and with community groups. Because it was intended primarily for patients, however, A NEW CHAPTER is aptly titled. It will be interesting to see what develops from this pioneering effort.

JACK NEHER

USES OF THE PAST

IV. Selecting the Site

THE BEGINNING of psychiatric hospitalization in the United States was the removal of the mentally ill from their previous situations in cages, attics, jails, almshouses, and workhouses, where they had existed in uniformly pitiful states. Admission to the cellars of the Pennsylvania Hospital and the New York Hospital may have seemed to be but a meager improvement, but at least the patients were coming under medical auspices. Separately from other medical institutions, the Eastern State Hospital in Williamsburg, Virginia, began the long tradition of hospitalization of the mentally ill, and with the founding of an increasing number of similar mental hospitals, there arose a philosophy regarding the selection of the site which included numerous and varied factors.

One consideration probably present but not mentioned directly was the fact that the mental patient, not so long liberated from the ranks of the witches, provoked great public anxiety. Fear and revulsion still left their mark. For its own safety, the community felt that these patients should be located outside the town limits, but not so far away that trade was impossible or that jobs could not be filled. This removal also benefitted the patients in that they were protected from becoming objects of curiosity or sources of entertainment for the so-called "normal" population.

Financial aspects also weighed heavily in the deliberations. Finding sufficient acreage meant selecting areas outside the town, which led to a decreased initial cost. If the patients, as part of their occupational therapy, were to work in the gardens and in the dairies, the hospitals could hope to fulfill a large portion of their food needs. For that matter, Luther Bell, in his 1836 report, tempted the New Hampshire Legislature with the thought that the hospital might become self-supporting after the initial expenses of its foundation.

Nor were therapeutic concepts neglected. General health was emphasized by locating a site on an elevation where the air was fresh, good water available in abundance, and also, if possible, where calm and beauty existed. It was felt that the patient had to be removed from his surroundings in order to break away from previous painful and dangerous associations. Adequate land had to be provided so that the patient could participate in the occupational therapy of the day and find diverting recreation and exercise on the grounds of the hospital.

These principles had become so thoroughly accepted by 1851 that the Association of Medical Superintendents of American Institutions for the Insane recommended that future hospitals be located in the country, not less than two miles from a large town, and that a minimum of fifty acres be provided for any hospital, and preferably one hundred for a state hospital. The principle of separation of the hospitals for the mentally ill from the center of the community and from the other medical facilities had become well-established.

ERIC T. CARLSON, M.D.

Tenth Mental Hospital Institute Highlights

At the Tenth Mental Hospital Institute—a gathering of more than 450 people—there was an atmosphere strangely reminiscent of the First Institute, held in Philadelphia in 1948. At both meetings, historically so far apart, there was not only recognition of the many problems common to mental hospital administration, but a determination to solve them by unifying efforts on all levels.

Just as the First Institute was followed almost immediately by the formation of the Mental Hospital Service, the Tenth will be followed quickly by various innovations, groupings and programs designed toward the identical end of meeting the problems head on and of actively seeking solutions. The many new voices at Kansas City will be heard with increasing frequency in the months to come.

One problem which the Philadelphia Institute didn't face, but which has become increasingly acute with every succeeding institute, is that of participation in the discussions. This problem has already been discussed by the Medical Director with the new Program Committee and the Eleventh Mental Hospital Institute will be patterned in a somewhat different manner, in an attempt to sharpen the spontaneity of discussion and to bring more people into it.

Dr. Francis J. O'Neill of New York, is the Chairman of next year's Program Committee, with Dr. William S. Hall of South Carolina, and Dr. Alfred Stanton of Massachusetts. The names of the other two members—a Canadian and a business manager—will be announced.

Among the most interesting of the optional meetings were those of the Business Managers on Sunday, and the First Workshop for Commissioners which was held on Saturday, October 18th, sponsored by the A.P.A. and financed by S. K. & F. Both groups indicated their interest in the formation of new organizations in collaboration with the A.P.A. Mental Hospital Service.

The Commissioners went on record as favoring the organization of themselves into a permanent national group which will meet regularly to exchange information about their programs and how they may be further advanced. Those present at Kansas City designated themselves as a Committee of the Whole, pending formal organization. An executive committee, formed to work out details of the proposed organization, consists of: Dr. George Jackson, Kansas, Chairman; Dr. Clifton Perkins, Md., Vice-Chairman; Dr. Harold McPheeters, Ky.; Dr. Hayden Donahue, Okla.; Dr. Granville Jones, Ark.; Dr. Addison Duval, Mo.; Dr. Cyril Ruilman, Tex.; Dr. John E. Davis, Pa.; Dr. Earl Holt, N.H.; and Dr. John B. K. Smith, Alaska. The executive committee is now communicating with Commissioners who were not in Kansas City, and it is hoped that a more detailed announcement will be ready for release within the next few weeks.

The Business Managers, pondering their own specific needs, appointed an ad hoc committee of five, to meet with the Medical Director and the staff of Mental Hospital Service early in the new year, to discuss what form their organization should take. This discussion group consists of Mr. Carl Applegate, Calif.; Mr. Alexis Tarumianz, Del.; Mr. William Brenizer, Ind.; Mr. A. C. Yopp, Ark.; Charles O'Connell, N.Y., and Joseph Greco, Mo.

Another optional meeting held on Sunday afternoon was chaired by Mrs. Miriam Karlins, of Minnesota. Directors of Volunteers came from Maryland, South Carolina, Missouri, Kentucky, Illinois, Ohio, Indiana, Kansas, Oklahoma and Pennsylvania. Their discussion emphasized the need for some method of communication among volunteer coordinators and directors, especially the opportunity for them to meet together as a group for mutual discussion. Miss Mary Mackin, representing the N.A.M.H. presented tentative plans for a training program for volunteer coordinators to be sponsored by her organization, a suggestion which was received enthusiastically. Mrs. Karlins was requested to bring these ideas to the attention of the Mental Hospital Service and to explore with this group the possibilities of arranging for future meetings.

Dr. Mathew Ross, A.P.A. Medical Director, presents the 1958 Achievement Awards. L. to R., Dr. George Zubowicz, Supt., Osawatomie State Hospital; Dr. Ross; Dr. Cecil Wittson, Director, Nebraska Psychiatric Institute; Mrs. Miriam Karlins, Volunteer Coordinator, and Dr. Dale C. Cameron, Medical Director, Minn. Dept. of Public Welfare. Far right, Dr. E. Calvin Moore, New Jersey Neuro-Psychiatric Institute, who accepted on behalf of Dr. Robert E. Bennett, Medical Director.

How does the public measure healthfulness?

When judging healthfulness or the sanitation of an area, the layman depends on his eyes and nose. Even if an area looks clean he will be suspicious if a noticeable "cover-up" odor is present. Strong chemicals used to smother institutional odors may only disturb a patient, annoy a visitor and probably make the work of your staff more difficult.

Modern cleaning and sanitation systems, such as those developed by Airkem, include a combination of interrelated products to comfort the patient, assure the visitor and make the cleaning task easier. Airkem "A-3," for example, penetrates and cleans out dirt where soap and scrubbing cannot. It effectively combats the dangers of cross infection, kills odors on the surfaces and in the air and leaves a clean, air-freshened effect. This unusual combination of properties results from a unique formulation. Airkem "A-3" combines a non-ionic, synthetic detergent, a quaternary ammonium sanitizer, an organic chelating agent and Airkem odor counteractants.

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ened effect to indoor air. Through their proper use, a hospital can control even a serious odor condition without resorting to heavy chemical smells or adding perfume overtones to the air.

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ADMINISTRATIVE
Feature
Of The Month

PROFESSIONALIZING Food Service

By LOUISE S. HICKS, Food Administrator (Head Dietitian)
Agnews State Hospital, Agnew, Calif.

ADMINISTRATIVE REORGANIZATIONS in a large hospital, however desirable, bring their share of headaches in the early stages. A directive from the superintendent that such and such a change will take place is not enough. There must be a number of formal and informal conferences which must include practically everybody involved in the projected change.

In 1954, the California State Department of Mental Hygiene issued a directive that, in the future, food served in congregate dining rooms to patients throughout the hospital, beginning with our six large congregate dining rooms, should be served by Food Service Assistants instead of by nurses and psychiatric technicians. The advantages were obvious—the saving of nursing service time which could then be devoted to other aspects of patient care; better portion control, and greater administrative economy. (It was interesting to note that several technicians expressed a desire to transfer to the Food Service.)

Forty-six Positions Allocated

We were allowed 46 positions for our six congregate dining rooms, which serve approximately 2500 patients. This allows two employees for the morning shift, two for the afternoon shift and relief. Employees work a forty-hour week, with 15 paid vacation days, and from nine to thirteen holidays and twelve sick days annually.

Before a dining room was taken over, a meeting was held with the following: the superintendent of nurses, the food administrator (head dietitian), the nursing personnel assigned to the dining area, and the food service employees who were initially to work in the dining room. At this meeting the reorganization was explained, and cooperation from the nursing and medical services was sought. Without this cooperation, especially from the nursing service, we would have been up against a difficult task. As it was, the nursing and medical service agreed to help.

A 40-hour orientation course was given to the new food service assistants, most of whom had never before been employed in a mental hospital or come into contact with mentally ill people. Orientation consisted of safety rules, hospital rules and regulations, functions of the hospital, ethics, kinds of admissions, sanitation, business administration, first aid in emergencies, the elements of psychiatric treatment and of rehabilitation and industrial therapies, and the functions of the nursing service and of social service.

While the new employees were receiving the forty-hour course, trained and experienced food service assistants were assigned to two congregate dining rooms to work with the nursing personnel one week before taking over officially. Thus the transfer was made smoothly with no change in the existing routine. The new employees were hired on a twelve-a-month basis so that they could be oriented and start their on-the-job training before another group came in. After the first group had completed orientation, its members were assigned to the two dining rooms taken over by the food service assistants. By the time the second group was ready for assignment, the first twelve were able to take over the first two congregate dining rooms—releasing the experienced food service employees to take over two more dining rooms. The second group, after orientation, took over from the first group, who, in turn, moved up to take over from the original experienced food service employees who moved up to take over the last two dining rooms. This progression worked out well with a minimum of problems.

Ward Serving Areas Staffed

Once this change-over was completed, we were faced with the somewhat different problem of taking over eight ward serving areas, each of which served two small wards in a common dining room. First of all, a conference was held with the superintendent of nurses, the area nursing supervisor, all the nursing personnel in the serving area, the food administrator, the food service supervisor and the food service assistants who were to replace the nursing personnel. At this conference, tentative policies were outlined, possible problems discussed, and an appeal made to the nursing service personnel to help the food service people as much as possible. Food service personnel were to work with the nursing personnel for three days before taking over officially. The eight ward areas were taken over one at a time, using the same procedure that had been used in taking over the congregate dining rooms. One firm rule had to be established in the ward serving areas: the kitchens would be securely locked and only food service employees had the key. This was necessary because food service employees are responsible for the food, and dual responsibility is not effective. Nursing and medical personnel were

disturbed because the kitchens would be locked at night. However, they finally accepted the idea when they found that food service assistants were conscientious about preparing and leaving out the evening nourishment, consisting of warm milk or chocolate in thermos flasks, together with cups and glasses. When a party is scheduled, the kitchen is stripped of supplies and the entire area left open for the night.

By locking the kitchens at night, it is possible to keep such items as the breakfast bacon, sausage and eggs on hand. They are sent over the night before, so the afternoon shift food employees can do as much as possible to make the morning shift's task easier. A week's supply of coffee, sugar and tea is also kept on hand.

Silverware Presents Problems

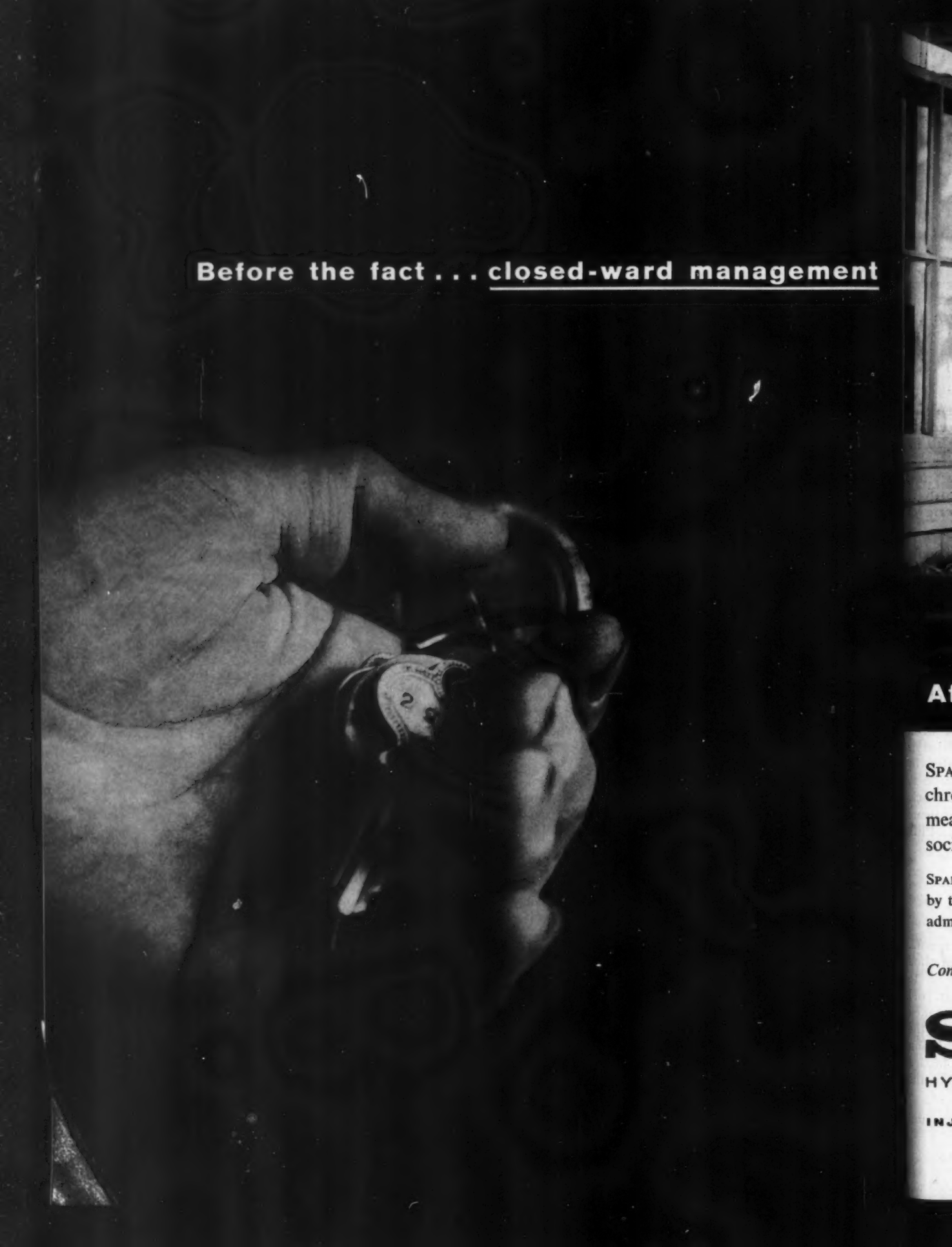
Counting silverware presents a problem not yet satisfactorily solved. Food service employees tell the nursing personnel how many sets were given out and at the end of the meal, the nursing personnel collect and count it. A food service assistant also counts silverware before and after washing it.

While food service personnel are responsible for serving the food, the nursing personnel remain responsible for the supervision of the patients while they are eating. They bring the patients to the dining room and escort them back to their wards. They give special attention to patients on one of the different therapeutic diets, and take in the trays served to patients who are too ill, physically or mentally, to come to the dining room.

One of the advantages is effective portion control, and for this purpose each serving area is equipped with different sized ladles, spoons and food tongs. A directive from the food administrator specifies which size ladle to use for the serving of different types of foods. The electrically heated food carts are loaded according to the ward population and the size of the servings. It has been found that men eat more than women, especially of potatoes and bread, while women eat more salad. However, care is taken to make sure each patient receives a balanced diet. This is taken into consideration when making out production lists and loading the food carts.

Food service assistants prepare salads, grill steaks, chops and hamburgers, prepare eggs, fry hot cakes or French toast—in fact, prepare anything on the menu which can be done on a short-order basis. They also prepare intermittent nourishments, and check overages and shortages. On the ward where there are no food service assistants, the food department supplies each serving area with supplies and gives recommendations pertaining to the serving of the food.

At present the food service department is serving three-fourths of the meals at the hospital. As the legislature sets up sufficient new positions and the wards are modernized, there will be more common dining areas under the control of the food service. The same method of taking over will be used. Now that the nursing service has discovered the many advantages of the new system, we anticipate little or no difficulty in completing the change-over.


Before the fact . . . closed-ward management

After the fact . . . rehabilitation

SPARINE quickly controls the excitement and hostility of acute and chronic psychoses. As a practical adjunct to formal psychiatric measures, SPARINE simplifies care, facilitates accessibility, speeds social rehabilitation.

SPARINE gives prompt control by intravenous injection and effective maintenance by the intramuscular or oral route. It is well tolerated in all three methods of administration.

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A Wyeth normotropic drug for nearly every patient under stress

HIGH POINTS OF OUR PREVENTIVE MAINTENANCE PROGRAM

By HUGH H. MULHOLLAND
Superintendent of Grounds and Buildings
The Pennsylvania Hospital, Philadelphia

THE ALL-IMPORTANT PRINCIPLE of an effective maintenance program is the interest and pride of the personnel of the hospital in keeping up the appearance of the buildings and grounds, and in keeping equipment in working order. Any successful program will depend largely on the degree to which all employees are involved in the prompt reporting of minor trouble, and thus taking responsibility for some of the basic maintenance work. Following are some of the high points which we have evolved in the development of our preventive maintenance program:

Inspecting

• As soon as leaks in boiler walls are discovered, they are sealed with Stonhard Crack Filler, a material which sets quickly, without shrinkage. (Obtainable from Stonhard Company, 1306 Spring Garden St., Philaphia, 23.) Steam and water line leaks are likewise corrected before they become big.

• Wall cracks caused by settling buildings are corrected by using Stonhard Crack Filler immediately when they are noticed.

Repairing

• Fuel oil consumption is watched constantly. Any increase in consumption is checked, the cause determined and the fault corrected as quickly as possible.

• Steam traps and by-passes on steam lines and heating systems are checked, any leakage noted and corrected quickly. Expansion valves are repacked as needed.

• Leaks in underground water and steam lines are corrected by digging trenches at the leak area and replacing the bad sections of the line. The new sections are installed by using dresser fillings which last for years.

Scheduling

Periodic oiling and cleaning of condensers insures constant working of refrigerator equipment.

• The Paint Foreman maintains a log book, recording the date last painted, color of paint used, time and material used on all essential projects. This insures that proper painting is scheduled for spring, summer or fall; a backlog of inside jobs is kept for rainy days.

• Outside cement wall repairs are similarly scheduled.

• Periodic cleaning and oiling of elevator equipment, including the folding gate guides, and the replacement of defective contacts insures continuous service.

• A cleaning solution called "Vapico" is run through flake ice and ice cube machines every three months. (Obtainable from the Garman Company, St. Louis, Missouri.)

• Periodic cleaning, oiling and adjusting of laundry machinery saves considerable time and expense and permits constant service.

• Clogged drains caused by dishwashing grease can be avoided by using grease traps. Drains are cleaned with two small cans of "Nyco Special Plumbers' Ideal" once a month. (Obtainable from Nyco Products, Inc., 1801 South Jefferson Street, Chicago.)

Reporting

• Correcting small faults prevents major problems. Members of all departments are requested to develop the habit of watching for leaks in water, steam or head lines, and noisy pipes in the heating system and report such faults to the Engineering Department.

• Daily log sheets are maintained at our power plants.

Replacing

• A large percentage of cartridge fuse troubles and failures are caused by dirty, loose fuse caps, poor connections of fuse refills or overloads. We clean fuse ferrules; clean or renew fuse clips and make clean, tight connections on fuse refills. When the budget permits, it is advisable to replace fused panels with circuit breakers which save many hours of labor and fuse replacement costs.

• Old DC generators are replaced with selenium rectifiers. Rectifiers must be at least 25% oversize to insure safety and constant service. A spare unit is kept for emergency use. For elevators, it is necessary to have a regenerative unit to take care of surges.

• Using one good standard make for all bathroom fixtures permits compact storage of supplies and saves maintenance expense. Old water lines are replaced with good grade copper tubing and fittings.

• The "Kassway Self-Guiding Tank Ball"—consisting of a non-kinking chain on the top and at the bottom of a rubber ball attached to the ball seat—is used to correct loose or worn out rods in the water tank. Old style rods and supports are eliminated by this device which acts as a guide to re-align the ball as it drops back. (Obtainable from Kass Hardware Company, 1836 Market Street, Philadelphia, 3.)

Trash Disposal Cage Saves Loading Time

Hastings State Hospital, Minnesota, has devised a more efficient method of transporting trash and refuse to disposal facilities. In the past, old cans, paper containers, etc., were taken to a designated storage area in the hospital and when the accumulation reached a sizable amount it was loaded on a truck by hand and taken to the dump.

This was a time consuming, un-

pleasant, and unsanitary job, especially when it had to be done during inclement weather. It usually took a crew of men including the truck driver more than four hours to complete the job.

In order to simplify this procedure we made an angle iron cage covered with cyclone wire on the sides and bottom and mounted it on a skid to facilitate loading in the truck. We erected a concrete platform the exact height of the truck body which made it easy to slide the cage directly into the truck without any lifting or straining by employees. The cage has a swinging end gate which automatically opens when the truck body is raised, allowing refuse to slide out freely.

We have two of these cages located nearby the buildings that need this service and when one is full we back up with the dump truck, slide the cage into it and haul it away. With this system, two men can easily empty both cages in less than an hour.

JOSEPH YANZ
Building Foreman

Hospital Solves Problems of Landscape Plant Propagation

Ornamental trees and shrubs for landscaping purposes are normally quite expensive. Therefore, it is highly economical for the hospital to propagate its own if facilities are available. The three obstacles to the successful propagation of plants are fluctuation of temperature, contamination of the soil with fungus and other plant diseases, and the inability to control atmospheric moisture.

At the Topeka State Hospital a successful program of plant propagation was achieved, in spite of inadequate physical facilities, by three simple procedures:

1. The installation of an electrical heat control cable in the germinating bench at the greenhouse insures continuous optimal temperatures.

2. The sterilization of the soil was accomplished by running a ¾" perforated copper tube in coil fashion in the bottom of a soil box measuring 9 x 6 x 6 ft. This steam coil was covered with six inches of coarse gravel, and several feet of soil. By connecting the tubing to a low pressure steamline and permitting the steam to pass freely through soil, we raised the internal soil temperature to 210 degrees for 24 hours, effectively sterilizing the soil.

3. Moisture control of the propagating bench was accomplished by erecting a frame of strap-aluminum and covering it with clear Visqueen film. The result is a tent that will contain heat and moisture while still admitting sunlight.

Now we have the beginnings of a fine selection of trees and shrubs in the nursery, which, incidentally is cared for by our patients. They seem to enjoy caring for plants and watching them grow. We feel that the hospital gains in two ways from such a program: first in an economical source of trees and shrubs, and second, in a good program of industrial therapy.

R. GASSDORF
Landscape Architect

Personal Interview Record Answers "Old" Questions

What happened to my W-2 Form? Did you mail that claim form to the Insurance Company? What date did I tell you my license was due? When did I file for my group insurance? Did a loan company verify my employment?

Is your personnel office bothered with questions like these, that you can't answer except from memory? Ours was, at Rusk State Hospital in Texas, so we started keeping a record in the folder of each employee who came in or called for any reason. We use a sheet called an Interview Record, and each time we take action for, or talk with any employee we make a record of the date, purpose of call, what was done and the initials of the office employee who held the interview. We also use these sheets to record information about and impressions of applicants. Much of the information otherwise would not be recorded, and might seem trivial to you, but not to the *employee concerned*. With the Interview Record to aid your memory you will be able to answer questions like those above six months later.

The value of this record can hardly be realized until you have had it awhile, but after you use it we'll bet you wouldn't be without it.

WILLIAM B. McSWAIN
Personnel Officer

Venetian Blinds Present Cleaning Problems

The most time consuming cleaning operation in the C. F. Menninger Hospital is the cleaning of the venetian blinds, which are installed between the security screens and the outside windows. This type of installation allows either patients or staff to regulate the light from the window. The wires which tip the slats up and down are manipulated by a metal disc about 2½ inches in diameter, mounted inside the stationary metal frame of the screen and extending ½ inch through the frame into the room. One tips the slats up or down by rotating the disc up or down with the finger tip.

In order to clean the blinds we must unlock the screen; and since the slats are wider than the screen opening (because of the stationary frame) they cannot be pulled out from the window to be wiped down on the other side. Hence each slat must be dusted and cleaned individually. We believe, nevertheless, that the additional time and cost for housekeeping to clean these blinds is outweighed by the convenience and security the blinds give to the patient and staff.

HELEN JOHNSON
Executive Housekeeper

STELAZINE*

A NEW ANTIPSYCHOTIC AGENT

OFFERING FIVE SIGNIFICANT ADVANTAGES

1 effective in withdrawn, apathetic schizophrenics

2 effective in chronic patients refractory to other therapies

3 marked beneficial effect on delusions and hallucinations

4 fast therapeutic responses at low doses

5 inherent long action

'STELAZINE'
ANTIPSYCHOTIC

for treatment of chronic and withdrawn schizophrenics

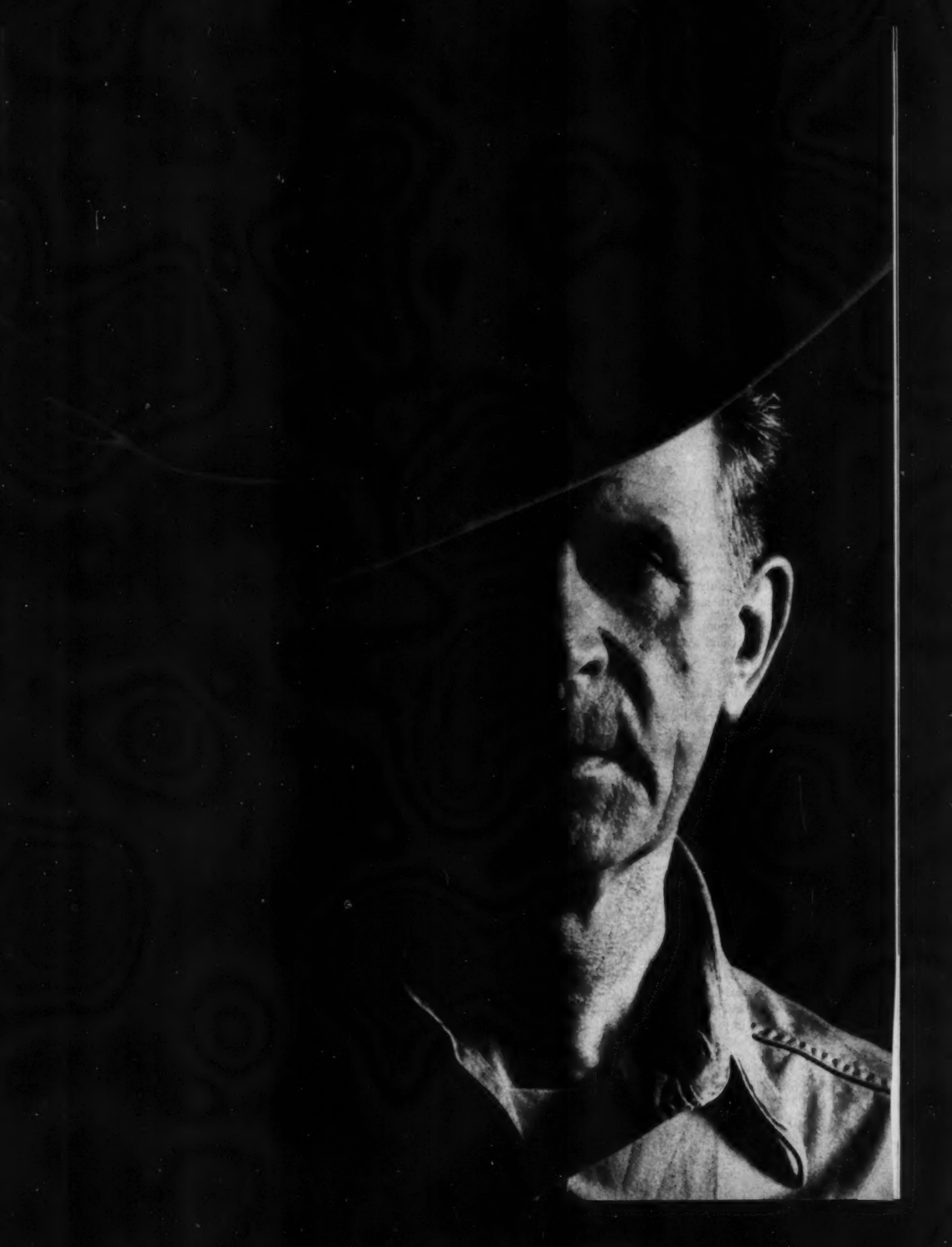
'Stelazine' is the first psychopharmacologic agent to be effective in significant numbers of chronic and withdrawn schizophrenic patients.

Prime candidates for 'Stelazine' therapy are the "back-ward," withdrawn patients for whom drug therapy has been abandoned or perhaps never attempted. Clinical studies have demonstrated that on 'Stelazine' therapy these patients become alert, communicative, sociable and responsive to the therapeutic milieu. Many appear to be beneficially motivated, and for the first time show an interest in leaving the hospital.

It is Stelazine's effectiveness in these patients that has set it apart from other psychopharmacologic agents. Withdrawal should be considered an indication, rather than a contraindication, for 'Stelazine'. Moreover, chronicity and failure to respond to other drugs are good reasons for a clinical trial.

We are convinced that once you have tried 'Stelazine' in your chronic and withdrawn patients you will find that this drug is truly a different and very important addition to your armamentarium.

Smith Kline & French Laboratories
Philadelphia



ADMINISTRATION AND DOSAGE OF 'STELAZINE'

'Stelazine' dosage must be adjusted to the severity of the condition and to the response of the individual. Dosage should be titrated carefully in order to achieve maximum therapeutic effect with the lowest possible dose.

'Stelazine' is intended for use only in patients who are either hospitalized or under adequate supervision. As yet, dosage has not been established for children under 12 years of age.

Oral

The usual starting dose is 2 mg. t.i.d., but many patients can be started satisfactorily on 5 mg. b.i.d. (Small or emaciated patients should always be started on the lower dosage.)

The majority of patients will show optimum response on 5 mg. t.i.d. or 10 mg. b.i.d., although a few may require 30 mg. a day or more. Optimum therapeutic dosage levels should be reached within 2 or 3 weeks after the start of therapy.

When maximum therapeutic response is achieved, dosage may be reduced to a satisfactory maintenance level. Because 'Stelazine' is inherently long-acting, maintenance doses can be administered b.i.d.

Intramuscular (for rapid control within hours)

The usual dose is 1 mg. to 2 mg. (½ cc.–1 cc.) by deep intramuscular injection every 4 to 6 hours, as needed. More than 6 mg. within 24 hours is rarely necessary. As soon as a satisfactory response is observed, oral medication should be substituted at the same dosage level or slightly higher. If motor restlessness or jitteriness occurs, the dosage should *not* be increased. See "Side Effects" below.

Only in very exceptional cases should dosage of 'Stelazine' Injection exceed 10 mg. within a 24-hour period. Since 'Stelazine' has a relatively long duration of action, *injections should not be made at intervals of less than 4 hours* because of the possibility of an excessive cumulative effect.

'Stelazine' Injection has been exceptionally well tolerated; pain and induration at the site of injection have not been reported.

SIDE EFFECTS

Clinical experience has shown that when side effects occur, their appearance is usually restricted to the first 2 or 3 weeks of therapy. After this initial period, they appear infrequently even in the course of prolonged therapy. Termination of 'Stelazine' therapy because of side effects is rarely necessary.

Extrapyramidal symptoms

Extrapyramidal symptoms are seen in a significant number of patients given 'Stelazine'. These symptoms may resemble Parkinsonism or be of the dystonic type. The muscles of the face and shoulder girdle may be selectively involved. Symptoms observed have included: spasm of the neck muscles, extensor rigidity of back muscles, carpopedal spasm, oculogyric crisis, trismus and swallowing difficulty. Occasionally, there may be elements of excitement and increased suggestibility.

Despite some similarity to symptoms of serious neurologic disorders, these extrapyramidal symptoms are reversible. They subside gradually—usually within 24 to 48 hours—when dosage is lowered or the drug temporarily discontinued. If desired, they may be more promptly controlled by the concomitant administration of anti-Parkinsonism agents. Severe dystonia has responded rapidly to intravenous caffeine sodium benzoate.

Akathisia (motor restlessness and turbulence)

Some patients may experience an initial transient period of stimulation or jitteriness, chiefly characterized by motor restlessness and sometimes insomnia. These patients should be reassured that this effect is temporary and will disappear spontaneously. If this turbulent phase becomes too troublesome, reduction of dosage or the concomitant administration of small doses of phenobarbital or some other mild sedative may be helpful.

At times, this effect may be strikingly similar to the original anxiety manifestations of the psychosis. Thus, it is important to identify these symptoms as a side effect, and to see to it that the dosage of 'Stelazine' is *not* increased until these symptoms have disappeared.

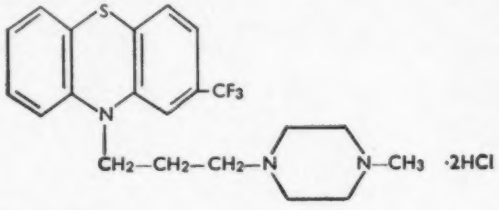
Others

Other side effects have been minor. Drowsiness has occurred but has been transient, usually disappearing in a day or two. There have been occasional cases of dizziness, muscular weakness, anorexia, rash, lactation and blurred vision.

'Stelazine' is contraindicated in comatose states. For further information, see the S.K.F. literature.

CHEMISTRY

'Stelazine' is 10-[3-(1-methyl-4-piperazinyl)-propyl]-2-trifluoromethylphenothiazine dihydrochloride.



AVAILABLE

'Stelazine' Tablets: 2 mg., 5 mg. and 10 mg., in bottles of 50 and Special Hospital Packages* of 1500.

'Stelazine' Injection: 10 cc. Multiple dose vials (2 mg./cc.), in boxes of 1 and Special Hospital Packages* of 20.

*Available only to non-profit and government hospitals.

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ARCHITECTURAL Feature Of The Month

Patio with country club setting is designed to promote a friendly atmosphere where patients may relax and chat.

THE "SALUTARIUM" - A NEW CONCEPT IN O.T.

By MARGARET E. COLES*
Norwich State Hospital, Conn.

THE HOSPITAL ATTEMPTS, through its occupational therapy program in association with the medical and nursing services, to organize the patients' activities in a normal, community type order, with periods set aside for work, relaxation, and play. The purpose is to simulate a day under ordinary conditions of life; the goal, to return the patient to his place in society a better integrated person.

Although experts have long appreciated the value of occupational therapy in the rehabilitation of the mentally ill, it is often applied on a catch-as-catch-can basis. Here, for example, in the past the occupational shops were scattered throughout the various buildings, wherever space was available. Facilities located in basements and odd corners were usually unsatisfactory and the shops themselves did not serve their purpose.

Building Designed to Meet Specific Requirements

Dr. Ronald H. Kettle, Superintendent, and the trustees decided that, to be truly effective, occupational therapy should be given a new emphasis and orientation. They wanted, first of all, a building especially designed to have all related activities under one roof. They toured the country looking for a model but, while a number of progressive hospitals had occupational therapy buildings, they saw nothing they felt would meet their specific requirements. Lacking a protoype, they hired the architectural firm of Ebbett, Frid and Prentice, Hartford, Conn., to design the building they wanted.

Unit Considered Unique

The resulting unit is considered unique in the United States, and is often visited by psychiatrists from abroad as well as from our own country. Norwich has even coined a new word for its Center—the Salutarium.

Of the three thousand patients in the hospital, seventeen hundred use the Occupational Therapy Building. The planners took into consideration the problems a mental patient faces and the handicaps he must overcome, so that in effect the patients' needs formed the blueprint of the building. For instance, the mentally ill person lacks self-confidence and is often apathetic. An environment which is attractive and friendly is important to arouse his interest in himself and his sur-

* *Ed. Note—In reply to our inquiry as to her title, Mrs. Coles replied, "I hold no title in the hospital but am one of the many enthusiastic volunteers."*

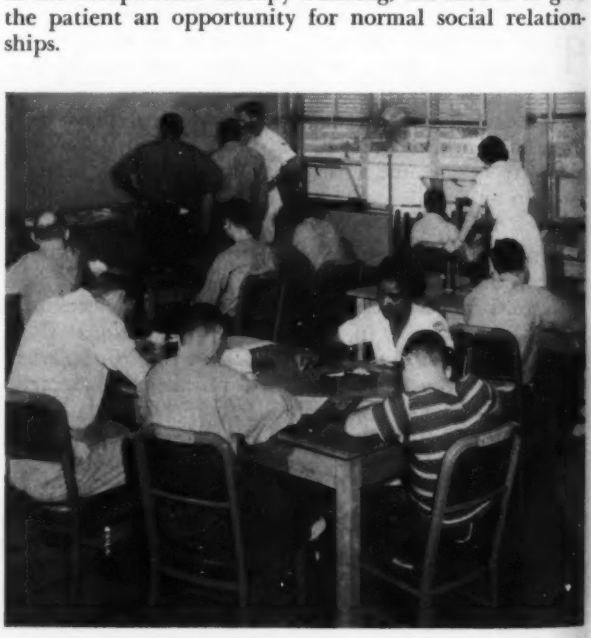
Many paintings produced in the commercial and fine arts shops are excellent in quality and are permanently hung in the hospital corridors. Occasional exhibitions are given in the city.

roundings. The occupational therapy building, therefore, was planned not as an architectural monument, but rather as a relaxing workshop and social center. There is not a single locked shop in the building yet, no patient has ever tried to leave.

Located at one end of the hospital grounds, and connected by tunnels to the other hospital buildings, the Salutarium has two stories and basement. Its focal point is the canteen, which opens onto an attractive patio separated from the main room by large plate glass windows. Wide doors lead down steps to a terrace, where tables with gaily colored umbrellas are grouped around a shallow pool. The pool, stocked with goldfish, is shaded by apple trees. This country club setting is designed to promote a friendly atmosphere in which patients may relax and discuss their activities. Since the patio is a closed court, no other hospital buildings are visible.

Canteen Has Social Atmosphere

The canteen is equipped with a snack bar, tables and booths, where light meals, coffee and sodas are served to patients, guests, and employees. Patients with grounds privileges may visit here at any time. It is an airy room, decorated in pleasant shades of apricot and at one end is a shop where candy, cigarettes, and small articles for personal use are sold. Patients use the canteen almost as they would a regular shop, or restaurant. (Those with spending money receive, as they enter the room, a slip showing the balance in their account. The amount of their purchase is then deducted from the balance and the slip returned to the patient, with a duplicate filed in the hospital office.) The atmosphere is one of warmth and sociability. A volunteer who had worked in the canteen for two days had the impression that the patients were completely unattended. Actually attendants are always in the room, although they make themselves as inconspicuous as possible. Here, as in all other shops in the occupational therapy building, the idea is to give the patient an opportunity for normal social relationships.



Admission clinics determine patients' occupational needs.

Patients in the ceramics shop develop their powers of self-expression in the production of useful and decorative pieces.

Rugs and mats for the hospital are produced in the weaving room, which is well equipped with various types of looms.

The library is also on the first floor. It is a spacious room with an excellent selection of books and magazines and is open to ambulatory patients each afternoon. Patients may browse or relax in comfortable chairs and may take out as many books as they wish. It is run in the same fashion as a professional lending library. Four thousand books are loaned out a month. Every morning books and magazines are taken by a hospital worker to the infirmary, medical, surgical, and disturbed wards, where patients may make a selection.

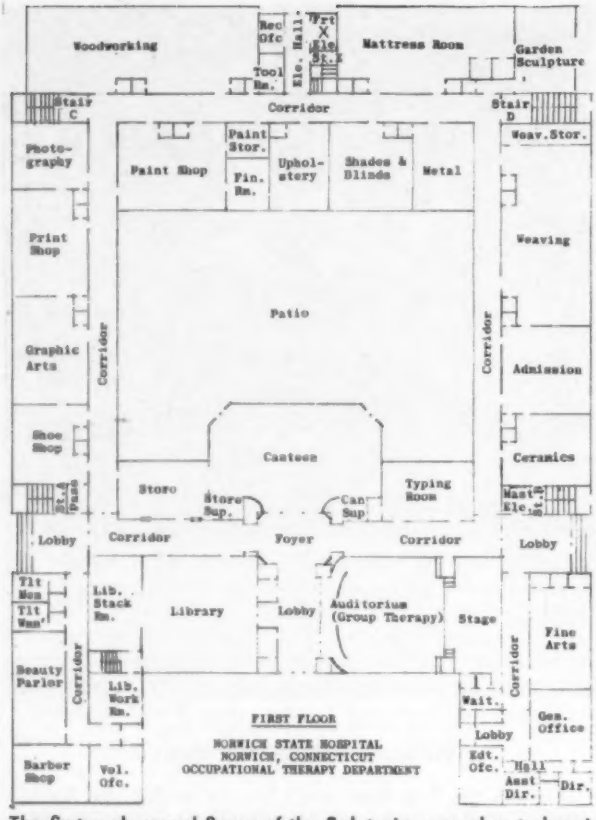
One of the most handsome rooms in the building is the auditorium across the lobby from the library. It has a large stage for psychodrama and in addition is often used for meetings of hospital personnel and volunteers, and for illustrated lectures to staff and students.

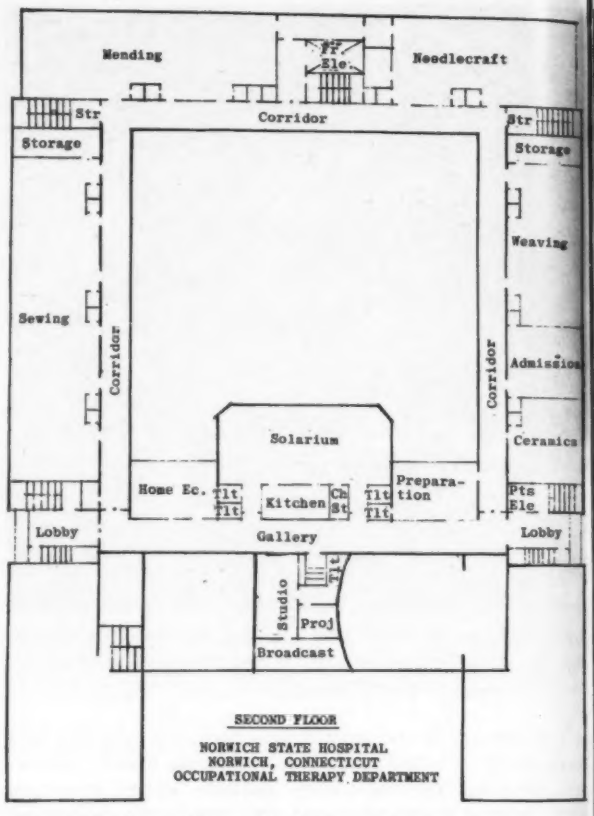
Volunteers Have Own Office

Also on the first floor are a beauty parlor and barber shop as well as general offices and a special office for volunteers. More than two hundred of these community representatives work in the occupational therapy program, visiting informally with the patients, joining them in recreational activities, giving concerts and parties, etc. Hospital authorities are agreed that they perform an invaluable service and Mr. Harry Kromer, who directs the occupational therapy program, says, "In the year since we started the volunteer service, these people have

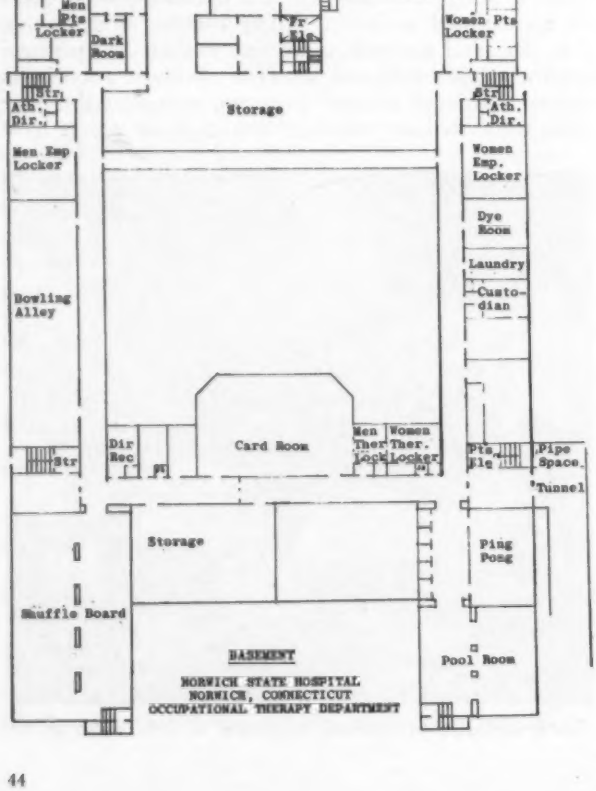
Evaluation clinics established patients' proficiency level.

Live broadcasts to hospital originate in O.T. radio room.





The first and second floors of the Salutarium are devoted mainly to occupational workshops; the basement to recreation. Landscaped central patio provides a private outdoor area for relaxation.



been of such help to us that we do not know how we ever managed without them."

Occupational Workshops Well Equipped

The occupational workshops are on the first and second floors and may be roughly divided into two categories—industrial and creative. The industrial workshops all have completely up-to-date equipment and the finished products are actually used in the hospital. The printing shop, for example, is equipped with hand and mechanical typesetters, mimeograph machines and professional machines for cutting large stacks of paper to desired size. Patients, under the direction of trained personnel, print daily report sheets, other forms, form letters, menus, and scratch pads for the hospital. In the photography shop they learn the latest photographic techniques and are engaged in building a hospital film library. In the sewing and mending shops, women patients make and repair simple cotton dresses, mattress covers, and other furnishings for the hospital. The shoe repair shop, under the supervision of a professional shoemaker, repairs all the patients' shoes, and makes cloth slippers, using discarded clothing for material. All materials, except leather and thread, are salvage, and no profit is made on either the slippers or shoe repairs. In the carpentry and painting shops new furniture is made for the hospital, and old furniture is repaired and refinished.

The creative shops, which include fine arts, graphic

Bowling alleys provide recreation and exercise for patients.

Volunteers conduct group singing sessions in the auditorium.

arts, weaving and ceramics, also have the very latest equipment, and the products are useful to the hospital. The emphasis is on developing the patients' powers of self-expression and promoting interests for them after discharge. The work produced in the commercial and fine arts shops is often excellent in quality and many of the paintings are permanently hung on the corridor walls. Occasional exhibitions are given in the hospital and in Hartford. The ceramics shop makes everything from simple clay pots to decorated figurines. In the weaving shop, equipped with several types of looms, the patients make rugs and mats for use in the hospital. Cuttings from the sewing room, and discarded sheets provide the material. These are dyed by the patients in a special room next to the laundry in the basement.

Also in the basement are recreational facilities, lockers, and showers for the patients. There is a card room, ping-pong, and pool tables, bowling alleys, and a space for shuffleboard and dancing.

Radio Broadcasting Room on Second Floor

Musical programs are broadcast throughout the hospital all day from the occupational therapy building's own radio room on the second floor. These programs are announced by patients, who write their own scripts. They also give a review of hospital sports activities and broadcast musical programs given in the hospital theater. Tape recordings of programs from commercial radio are rebroadcast to the hospital. Live programs directed by patients are also part of the occupational therapy broadcasting activities.

When a patient is admitted to the Norwich State Hospital, he is taken to either the Men's or Women's Admission Ward. As soon as possible he is assigned to an Evaluation Clinic on that ward to determine his occupational needs. Ward occupations range upward from kindergarten level, and include painting, weaving, and even reading and writing for those whose intelligence or education is below average. The patient progresses from one activity to another, and when ready, is assigned by the Director of the Industrial Program to one of the shops in the occupational therapy building. If he does not fit readily into the shop to which he is originally assigned, he is sent to the Evaluation Clinic in the building for observation of his behavior and work habits to establish his capabilities and proficiency level. He is then transferred to an appropriate workshop.

The occupational therapy program at Norwich, with its new and unique building, has had enormous success in carrying out its objective. The dedicated men and women responsible for this program feel that patients are being discharged better able to face reality and take their places in society.

- postoperatively
- in pregnancy when vomiting is persistent
- following neurosurgical diagnostic procedures
- in infections, intra-abdominal disease, and carcinomatosis
- after nitrogen mustard therapy

for nausea and vomiting

VESPRIN

Squibb Trifluprom**a**zine

- provides prompt, potent, and long-lasting control
- capable of depressing the gag reflex
- effective in cases refractory to other potent antiemetic agents
- may be given intravenously, intramuscularly and orally
- no pain or irritation on injection

ANTIEMETIC DOSAGE:
Intravenous: 8 mg. average single dose
Dosage range 2-10 mg.
Intramuscular: 15 mg. average single dose
Dosage range 5-15 mg.
If subsequent parenteral dose is needed, one-half the original dose will usually suffice
Oral: 10-20 mg. initially; then 10 mg. t.i.d.

SUPPLY:
Parenteral solution – 1 cc. ampuls (20mg./cc.), 1 cc. multiple dose vials (20 mg./cc.)
Oral tablets – 10 mg., 25 mg., 50 mg., in bottles of 50 and 500

SQUIBB

Squibb Quality – The Priceless Ingredient

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People & Places

ILLINOIS: **Dr. J. L. Meduna,** of the Department of Psychiatry, University of Illinois College of Medicine, Chicago, was elected an honorary member of the Royal Medico-Psychological Association, the British equivalent of A.P.A., thus becoming one of the five living foreigners to receive this honor . . . **Dr. Thomas T. Tourlentes** has succeeded **Dr. Lester H. Rudy** as superintendent of Galesburg State Research Hospital. . . . On October 1, **Dr. Joseph Marcovitch** was appointed to the position of superintendent of Jacksonville State Hospital. MISSOURI: **Dr. Louis Belinson,** formerly of Jacksonville (Ill.) State Hospital, is now deputy director of the Division of Mental Diseases, a newly created post in the state of Missouri. He will assist **Dr. Addison M. Duval,** director of the Division. KENTUCKY: Commissioner of Mental Health, **Dr. Harold L. McPheeters,** has added two new members to his department: **Dr. Joe L. Lawson, Jr.,** as psychology consultant, and **Dr. Harold William Conran** as director of professional services. OHIO: **Dr. Howard H. Peppel,** director of the Moundbuilders Guidance Center, Newark, a community mental health clinic, was called on to succeed **Dr. E. H. Crawfis** as acting superintendent of Hawthornden State Hospital . . . **Dr. Charles Waltner,** clinical director of Cleveland State Hospital, has accepted the superintendency of Woodside Receiving Hospital in Youngstown. HERE & THERE: During the recent meeting of the Southern Psychiatric Association in Nashville, Tennessee, A.P.A. President, **Dr. Francis J. Gerty** was made an honorary citizen of the city . . . **Dr. Mathew Ross,** A.P.A. Medical Director, was elected a Fellow of the Southern Psychiatric Association . . . **Dr. Robert E. Bennett** replaced **Dr. Robert S. Garber** as director of the New Jersey Neuro-Psychiatric Institute in Princeton . . . After 34 years of service with the Provincial Mental Health Services of British Columbia, **Dr. Arthur M. Gee** retired on August 31. **Dr. Allen E. Davidson** succeeds him as director of the service . . . President Eisenhower has promoted **Dr. Francis J. Braceland,** past president of A.P.A., to the rank of rear admiral . . . **Dr. Wayne Boyd** recently became clinical director of Western State Hospital, Ft. Supply, Oklahoma, succeeding **Dr. Quentin Brooks** who resigned . . . **Mrs. Caroline Heath, R.N.** has become the first director of nursing of Larned (Kansas) State Hospital.

Quarterly Professional Calendar

A.P.A. ANNUAL MEETING
1959 April 27-May 1st. Municipal Auditorium, Philadelphia
1960 May 9-13, Convention Hall, Atlantic City

A.P.A. MENTAL HOSPITAL INSTITUTE
1959 Oct. 19-22, Statler Hotel, Buffalo, N.Y.
1960 Oct. 17-20, Hotel Utah, Salt Lake City

Other Meetings, November, December, 1958, January, 1959:

NATIONAL ASSOCIATION FOR MENTAL HEALTH, Nov. 17-22, Kansas City, Mo.

A.P.A. DIVISIONAL MEETING, Dec. 1-3, Miami Beach, Fla.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, Dec. 15-16, New York, N. Y.

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, Jan. 23-24, New York, N.Y.

Retarded Girls Learn Homemaking

The Owatonna State School, a state-operated, residential unit for the higher grade mentally retarded in Minnesota, is experimenting with a new type of experience for older girls. Arrangements have been made with certain volunteers in the city of Owatonna to let one or two girls go into their homes and work with them for a day in order to have the experience of helping with the housework. This provides an opportunity for the girls to learn how to operate a variety of household appliances, such as washing machines, vacuum cleaners, etc.

The home visits are not intended to be training in the real sense of the word, but to provide experience in meeting and working with new people and seeing how housework and cooking are done in a variety of residences. The girls are not paid any money. It is assumed that the time and effort taken by the lady of the house and the experience gained by the girls is remuneration enough. In each instance a report is made to the hospital by the volunteer whose home the girls have visited.

The experience is actually broader for the girls than just that provided by working in the homes. They have to make all the arrangements with the lady of the house by telephone and arrange for their own transportation, or find the address by themselves.

As far as the experiment has gone, it has proven to be very satisfactory both from the viewpoint of the girls and of the volunteers who participate.

Mrs. MIRIAM KARLINS
State Volunteer Coordinator

Patients Weave Draperies For Central Office Staff

Thanks to some of the patients at the Mississippi State Hospital, the working quarters of the A.P.A. Central Office in Washington are taking on a plush look to go with the rest of the new building.

Twelve pairs of draperies and a cushion cover, woven by patients in the hospital's O.T. shop, were presented to the Central Office staff by Dr. W. L. Jaquith, Director of Mississippi State and one of the Mental Hospital Service Consultants.

First to put in a claim for draperies for his office was Dr. Mathew Ross, Medical Director. The red, brown, and white of the loose-woven material goes well with the high-backed red leather chair which Dr. Ross brought with him from California, and complements his polished mahogany desk.

Among other offices to be graced by the new drapes are those of the business manager and the Mental Hospital Service editorial staff.

The cushion cover was woven especially for the editorial office by Barbara, a patient from Cottage E at Mississippi State, and is in the same colors as the drapes but in one of the old Honeysuckle patterns. It is intended to convert the bottom shelf of four wide steps in the middle of the room into a settee for guests. (For those of our readers who are concerned about our stepping on the settee, we should explain that the four steps don't go any place but up. They were designed as a more utilitarian structure than the usual slanted wall, to cover a stair well.

A professional seamstress has been engaged to finish the draperies and cushion cover and it is expected that they will be completed and in place in time to dazzle the eyes of A.P.A. members who attend the fall committee meetings and the building dedication the end of this month.

Remotivation Reports Rosy

Less than three months after the formation of the first training team, the Remotivation Project is blazing away with all the enthusiasm of a prairie fire. So far, reports Dr. Robert S. Garber, Chairman of the Smith Kline and French Remotivation Project, 31 states have asked for the services of the Remotivation Training Team; the initial supply of one thousand manuals on Remotivation Technique is virtually exhausted and another four thousand copies are on order. There have been approximately 150 bookings of the film "Remotivation—a New Technique for the Psychiatric Aide" from the S. K. & F. Film Center.

Visits of the training team are currently scheduled for West Virginia, Virginia, North Carolina, South Carolina and Kentucky. There are tentative arrangements for visits to Indiana and Ohio during the winter, and Michigan, Wisconsin, Minnesota, Iowa, Kansas, Oklahoma and Nebraska will be scheduled after the first of the year. A final swing to the West will include Arizona, Colorado, New Mexico, Oregon and Washington and will carry the team until May of 1959.

Have You Heard?

COMMUNITY RELATIONS have taken to the air at two Illinois hospitals. Patients from the music therapy department at **Jacksonville State Hospital** present a regular monthly program over local radio station WLDS. At Elgin, station WRMN has been broadcasting a series of interviews with key personnel of the **Elgin State Hospital;** the interviews, which deal with such topics as alcoholism and juvenile delinquency, are conducted by the hospital's rehabilitation counselor, Mr. Green T. Wood . . . The **Utah State Hospital,** Provo, played host to the state's Public Health Nurses at a mental health workshop. . . . The ninth annual lecture series sponsored by the **North Shore Hospital,** Winnetka, Ill., will deal with "Emotional Forces in the Family". The series is open to physicians, clergymen, and members of allied professions. The nine lectures, to be given by prominent North American psychiatrists, will be published by J. B. Lippincott Co., with royalties assigned to the A.P.A. for public education.

CONSTRUCTION will start early in 1959 on a three-story addition to the Administration Buildings at **Patton (Calif.) State Hospital;** the $700,000 addition is expected to be completed in January, 1960. . . **Illinois** is planning to build a $5,500,000 pediatric hospital for mentally deficient children under 6 years of age; the 576-bed hospital, to be located in Chicago, is scheduled for completion in early 1960. . . . **Ontario,** Canada, also is increasing its facilities for the mentally retarded; a 1200 to 1300-bed hospital school is being built at Goderich and another institution, for adult and aged mental defectives, is planned for the Perth area. . . . **The Nebraska Psychiatric Institute,** Omaha, is building a three-story research unit, one floor of which will be a clinic for retarded children, and is adding a nursery to its children's service. . . . **Medfield State Hospital,** Harding, Mass., gave members of the press a preview of its new Clark Reception Building. It is the hospital's first new building since 1914 and was named for Dr. George O. Clark, who served on the Board of Trustees for 36 years. The 196-bed $2,225,000 structure contains the admission department, continued treatment wards and a medical and surgical unit. The new 21 million dollar 1011-bed VA Hospital was formally dedicated at Topeka on August 24. This hospital, of more than a dozen major structures and several smaller buildings, is "especially designed" for the care of neuropsychiatric patients.

VOLUNTEERS from the Ottawa Branch of the Canadian Mental Health Association have introduced puppetry as a new activity to the patients of the **Ontario Hospital, Brockville.** Patients are taught to make puppets and marionettes and soon learn to manipulate them well enough to stage their own shows. . . . Seven members of the German Shepherd Club of Washington D. C. brought their dogs to **St. Elizabeths Hospital** and entertained patients and employees with a two-hour demonstration of the dogs' prowess in retrieving. . . . A group called Act. Inc., sponsors the Fireside Social Club in San Jose, Calif. The Club is composed of patients discharged from **Agnews State Hospital,** VA, private and other state psychiatric hospitals. It aims to give its members moral support and job leads. In addition to weekly meetings held at the Unitarian Church in San Jose the club holds dances, picnics, plays. . . . Special complimentary fishing licenses were issued last summer by the Saskatchewan Department of Natural Resources for patients at the **Saskatchewan Hospital** at North Battleford.

VOCATIONAL REHABILITATION placements from the **Glenwood (Iowa) State School** were reviewed recently in the school's paper, *The Hill Topic.* In the year since the program was started with the State Office of Vocational Rehabilitation, 28 patients have been assigned to outside vocational training. Many are already working. Some surprising statistics: these patients range in age from 21 to 59, had been at Glenwood an average of 20 years (some as long as 48 years) and now are earning from $40 a month, plus room and board, up to $65 a week.

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